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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Ganglions. By FREDERIC C. SKEY, F.R.S., &c.—These small swellings, composed of a toughish cyst, are formed on one or other of the numerous tendons of the wrist. They rarely increase to a considerable size, and are not often seen larger than a child's marble. Their cause must be referred to undue and excessive action of the tendon, or rather of the extensor muscle leading to the tendon on which it is placed. Why they occur on that particular tendon I do not know. My reason for so thinking is because I have treated many cases in the persons of violin players, in whom the malady has been confined to the left hand, the right or bow hand being free; and it is not uncommon in pianists who devote many hours of the day to the practice of their profession. But they are not confined exclusively to this class of persons. Although free from pain, they are unsightly, and are always attended with some weakness of the hand, probably of the extensor muscles only. They are usually treated by rupturing the sac, and allowing its contents to invade the surrounding tissue. The instrument of violence commonly employed, and which has been, doubtless, handed down and adopted for many generations, is a thick bound book. The force of the blow is necessarily great, and the rupture of the sac does not invariably follow. This entails the necessity of a second blow. It is not certain that the force may be applied in the exact direction. To say nothing of the pain and the shock to a delicate girl, this treatment is by no means attended with

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invariable success; for I have known the fragments of the sac restored to their original places, and the disease remain *in statu quo*. I advise you to adopt in great preference to this coarse and old-fashioned treatment the following, which rarely fails to obtain an early, if not an immediate, cure. Its object is to evacuate the entire contents of the cyst, and to bring its opposite surfaces into perfect apposition with each other. It is a small operation; but on the delicacy of its performance its success materially depends. Bending the hand forwards, in order to tighten the skin over the cyst, pass vertically into the centre of the tumour a broad-shouldered lancet. By a lateral movement of the instrument the orifice will be dilated, and the contents will freely escape. Now it is indispensable to the obliteration of the cyst that the whole of its contents should be evacuated—every drop and every fraction of a drop, to effect which the sac must be compressed and kneaded in every direction. Then apply a well-made thick compress of lint, and strap it down tightly with good plaster, and, lastly, a roller may be applied. In forty-eight hours the wound has healed, and the ganglion is seen no more.

In cases (and I suppose I have operated on a hundred) in which the operation I described failed to cure the disease, the ganglion, as it will do when of long standing, had burrowed under the tendon. In one of these I attempted to dissect it out; but, in so doing, I denuded the tendon of its natural investment, and the result was permanent union between the tendon and integument. I never recall the circumstances of this case, and it occurred upwards of twenty years ago, without painful regret. The larger examples of a similar affection to the above—in which the synovial sac, probably the anterior one, which extends beneath the anterior carpal ligament into the palm of the hand, is the seat, and from which abundance of small melon-pip like bodies are obtained—may be treated on the same principle. But the subsequent pressure must be great.—*Lancet*, Aug. 27, 1870.

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Clinical Lecture on Abdominal Neuralgia. By Handfield Jones, M.D., Physician to St. Mary's Hospital.

This series of cases is interesting as illustrating the diagnosis and treatment of a disease that is not always easy to distinguish from other affections in which pain is referred to the abdomen, especially peritonitis, lead colic, and hysteria. The points on which Dr. Jones chiefly insists appear to be—1. That the region of the abdomen, probably its peritoneal lining, is liable to suffer from neuralgia and hyperæsthesia, such as prevail in other situations more notoriously prone to this malady. 2. That such neuralgic affections may very closely simulate peritonitis. 3. That they may be attended with high temperature. 4. That they may possibly pass into peritonitis. 5. That, in their treatment, opium (preferably in the form of enema), tonics and restoratives prove to be successful remedies.

The first case is that of M. W——, aged forty, a married woman, who was admitted on the 9th September. She stated that three days previously she had been seized with pain in the lower part of the abdomen and the hips, so violent as to draw her double; since the day before admission it had been gradually subsiding, but with occasional aggravations. Whilst the pain was at its worst the abdomen had been so exquisitely tender that she could scarcely draw her breath, and whilst sitting up she had felt sick. On admission she flinched violently when the left side of the abdomen was touched, and she felt pain on coughing or drawing a deep breath; when she turned on to the right side she experienced a feeling of dragging in the left; the tongue was thickly coated with white fur; the pulse was 78, and not very weak; the temperature 99.3°; there was no blue line on the gums. The right side of the abdomen was resonant, the left dull, and these sounds were not altered when she moved on to her right side. She had no appetite, but was very thirsty; the bowels were habitually confined; the urine was very red, and passed with pain; there was also pain on passing her motions; the catamenia had not appeared for six

weeks, but she had a profuse leucorrhœal discharge. There was no history of lead poisoning. She said that she lived over some stables, and had experienced a similar pain several times during the past three or four years; she felt very weak, and the least thing threw her into a "fainting perspiration." She had not been able to sleep during the previous night because dreadful sights appeared directly she closed her eyes—"blood and all that sort of thing, mice running about," &c. The bowels were first relieved by an aperient, and then an enema containing twenty drops of laudanum was administered, and followed by a great abatement of the abdominal tenderness. The treatment was then made to consist of one-twentieth of a grain of strychnia, one minim of nitric acid, and ten of chloric ether, in an ounce of water, four times a day; with simple diet, a pint of milk, and four ounces of sherry. On the second day her sleep had been disturbed in the same manner as before; the abdomen was quite soft and only slightly tender. On the third morning the sleep had been sound and uninterrupted; the bowels were relieved by an enema, and the diet was changed to chop, pudding, and porter, the medicine to twenty grains of the saccharated carbonate of iron, three times a day. On the seventh she was still improving, but, on getting up, the pain and feeling of faintness returned slightly. In a few days more she was discharged.

The second case was that of A. N——, aged twenty-six, a married woman with three children. She was admitted on Sept. 10th, and gave the following account of herself: She was in charge of a house which had just been painted, and smelt strongly of paint and varnish, when, three weeks before admission, she was attacked with severe headache, which, two days later, was replaced by an abdominal pain which she described as having been fitful in severity, and since its onset had been unable to lie on either side, or to obtain sleep at night. She had been feverish and without appetite. No other inmate of the house had been out of health. She looked thin and anæmic, had a copious leucorrhœal discharge, and was suffering such intense pain that six leeches were immediately applied to the abdomen, and followed by poultices. On the 13th Dr. Jones found her very weak, complaining of great pain on the left side of the abdomen, but lying with the legs extended; the left flank of the abdomen was dull on percussion; the other regions were resonant. The pulse was 102, not very weak; the temperature 102.5°; the tongue moist. There was no flush on the cheeks nor eruption on the abdomen. The bowels had not been open for two days; the appetite was good; the breasts did not secrete much milk. She was ordered an enema of castor oil, to be followed, after the action of the bowels, by a simple enema containing twenty drops of the tincture of opium; also a draught of four grains of carbonate of ammonia and one drachm of tincture of bark, in an ounce of decoction of bark, three times a day, with a generous spoon diet. On the fourth morning she awoke in great pain from a sleep which had lasted from early in the previous evening. The pulse was 105; the temperature 103.4°. The abdomen was fomented, and another opiate enema administered, and she was ordered twenty grains of the saccharated carbonate of iron thrice daily, in addition to the draught. On the seventh day the pulse was 88, the temperature 99.7°, and pain of a much less severe character recurred from time to time. The diet was changed to one of meat and porter. On the eleventh day the temperature was 100°, and, in consequence of copious night-sweats, the ammonia-and-bark draught was abandoned for one containing four grains of quinia. Subsequently a chloride-of-zinc injection was made use of to check the leucorrhœa. Twenty-eight days after admission she only complained of an occasional return of pain towards evening. No blue line was observed at any time on the gums.

The third case was also a woman, thirty-three years of age, and single. She stated that she had been indisposed for a fortnight, and had kept her bed for a week. The first symptom had been pain at the upper part of the abdomen, all

round it, and in the back, great pain also followed on taking food, and was relieved by vomiting. At the time of admission the pain seemed to be violent; she was found to be bending herself down and moaning; the tongue was moist, and tolerably clean; the pulse 80; the temperature 97.5° F. The abdomen moved a little in respiration, but the muscles were at times very hard and tense; there was no eruption. She had no appetite, but was very thirsty. On inquiring into her history, it was elicited that seven years before she had lived in a house whilst it was being painted, and that she suffered at the time some nausea; also, that two years before admission she had suffered, for a short time, a somewhat similar kind of pain. The teeth were found to be so incrusted and soiled with tartar that it was difficult to determine whether or not a blue line was present. She also complained that for a year she had had pain about the rectum, accompanied by a frequent desire to defecate; but she had never experienced any pain during the passage of her motions. The uterus was found to be reclined, the fundus lying near, if not upon, the rectum. She was first ordered a grain of opium every four hours, ice to swallow, poultices to the abdomen, and subcutaneous injection of ten minims of solution of opium; but neither these remedies, nor an opiate enema which had been administered, were found on the following day to have afforded relief. She was found to be twisting and writhing in bed, although the abdomen bore pressure fairly well. The pulse was 72, and not weak; the urine clear and of high colour. She was then ordered a drachm of tincture of valerian and four grains of carbonate of ammonia in an ounce of infusion of valerian, thrice daily; but she obtained no sleep during the following night, severe pain being excited every time she moved; and, in the morning, the abdominal walls were found to be hard and retracted. The temperature was 98.9° F. An opiate enema was followed by relief, and a grain of opium was ordered to be taken every two hours. On the eighth day two grains of iodide of potassium were added to the draught. On the fifteenth she was ordered in addition twenty grains of saccharated carbonate of iron, thrice daily. On the sixteenth day the pains became regularly paroxysmal, returning morning and evening at half-past ten o'clock. On the same date she began to sweat a great deal at night; ten grains of quinia daily, in two evening doses, reduced the severity but not the duration of the attacks. The amount of quinine was then doubled by giving four doses daily instead of two, and by the twentieth day she was free from pain and improving in general condition. After this the pains returned slightly, and a treatment as for lead colic was essayed, but, proving unsuccessful, was changed for citrate of iron and quinia, under which they soon began to disappear; and within little more than a month from the date of admission, though the patient suffered occasional returns of pain, the abdomen was soft and mostly quite free from tenderness on pressure, and she was discharged at her own request.

These cases, Dr. Jones said, were fair specimen cases of a disorder which is by no means rare, at least among the poorer classes. In calling it "abdominal neuralgia" he had followed unwittingly the example of the late Dr. Addison, who had written a very full and interesting paper on the same disorder in connection with uterine irritation. The term might be thought too vague, but he preferred it to any other, for the reason that it did not appear to him that any organ is specially affected, and that any part of the region in question might be attacked. If he were pressed to localize the disorder more exactly, he should name the peritoneum as the most probable seat, partly on account of the quality of the pain, partly because this membrane is coextensive with its situation. Romberg had described a hyperæsthesia of the mesenteric plexus, but the description he gave of it seemed more applicable to the colic than to the malady they were considering. A perusal of the cases, Dr. Jones thought, indicated that the resemblance of the symptoms, especially the pain, to those of peritonitis was quite close enough to make the diagnosis sometimes sufficiently difficult. Dr.

Addison had said that the pain occasionally attacked the whole of the belly, exactly simulating acute peritonitis, and that he knew of no more puzzling disease. The points which would prove most serviceable as guides were the previous history, the temperature, the posture, the respiration, the pulse, and the physical signs. If the patient appeared to have suffered from any cause of exhaustion, such as lactation, profuse leucorrhœa, over-exertion, semi-starvation, or the like, a neurosis was a more probable result than inflammation. If the disease was of long duration, such as from two to three weeks or more, and the pain persisted with severity, especially without the development of any other symptom, it could not be peritonitis; the same would probably apply if there was a history of several similar previous attacks. If the temperature underwent no rise, it afforded strong evidence against the existence of inflammation, though a high temperature could not by any means be taken to prove the converse. The second case indicated a temperature befitting typhoid fever, and it was only the sequel which conclusively showed that the pain was purely neurotic. It had been supposed that neuralgia could not coexist with pyrexia, but he had recently seen a case of ephemeral fever in which the patient complained of agonizing pain in the limbs, and the temperature rose to 103°; on the day following the pain had greatly abated, and the temperature was found to be normal. As regarded posture, the peritonic patient was said to lie in a fixed position, instinctively avoiding the slightest movement; the neuralgic often turns and writhes about: the former abstains from using the diaphragm in respiration, the latter does not, or, at any rate, not to so great an extent. After a few days the physical signs would probably afford decisive information. The dulness in depending parts of the abdomen, due to effusion, is not present in neuralgia. So, also, abdominal distension may be looked for in peritonitis, but not usually in neuralgia; though Dr. Addison speaks of a very marked instance of the latter, in which the belly was as tense as a drum and exquisitely tender. The case had been regarded as one of chronic peritonitis, and the surface of the abdomen "presented a most singular appearance from the thousands of leeches" which at various times had been applied. A very important question might be raised—viz., whether a primarily neuralgic disorder may not pass into an inflammatory. Dr. Jones's belief was that it might, and though he had not observed it in abdominal cases, yet there was considerable evidence, he thought, that such a change may occur in facial neuralgia. For further remarks on this topic he referred to his work on the subject. Some might be disposed to look upon these cases as examples of hysteria, and would have summarily dealt with them by the treatment which Sir T. Watson recommends—namely, purging followed by an assafœtida enema. To this he altogether demurred. If any definite meaning was to be attached to the term hysteria, it must imply that the patient's will was defective, that she was not sincerely anxious to get well; that, in fact, she wanted moral treatment more than medicinal. Such, he was satisfied, was not the case with the patients in question. The pain felt was, as far as he could judge, as *bonâ-fide* a pain as ever racked a sufferer from sciatica or tic douleureux; they recovered speedily, and under such treatment as was known to benefit neuralgia elsewhere.

The occurrence of some amount of nocturnal delirium, and that of a terrifying and distressing kind, in the first case, Dr. Jones added, deserved remark. Such disorder was, if he might use the term, quite homogeneous to neuralgia, both affections having their root in a feeble paretic state of nerve-centres, and being as it were branches of the same stock. The derangement, in fact, was of the same kind in both, and the diversity of phenomena depended on the site of the morbid action; the intellectual centres being affected in the one case, the sensory in the other. There were also indications that the vaso-motor nerve-centres were involved, and suffered in a like way; for the patient in the first case complained of "faint perspirations"—*i.e.*, perspirations

attended with a sense of faintness; and in the second, of copious nocturnal sweating, precisely such as is met with in maladies of exhaustion.

Another noteworthy point observed, especially in the first case, and which Dr. Jones said he had not unfrequently met with in other unquestionable neuralgias, was the reproduction of the pain by exertion. This depended on the fact (for such he held it to be) that consumption of nerve-force in one centre, or, to speak more correctly, of material qualified to generate nerve-force under oxidation, diminishes its production in another, and so favours the recurrence of a disorder which is essentially dependent on the failure of nerve-force.

The special cause of the disorder in these cases could not be said to be clearly ascertained. It might be thought that the second was of lead-poisoning, as the patient had been exposed to the smell of paint; but he could not take that view. There was no notable constipation, and no blue line on the gums. The pain was not like that of colic; it was attended with fever, followed by copious night-sweats, and cured by tonics. He had never seen anything like this in the frequent cases of lead disease he had met with. The lactation and leucorrhœa no doubt had materially promoted the action of the exciting cause.

The diagnosis once made, the remedies to be used were plain. Opium to relieve suffering, tonics to restore strength, the action of both being led, rather than seconded by repose and good nourishment. In doubtful cases, after ascertaining that the bowels had been sufficiently cleared, he advised the use of an opiate enema before applying leeches. The result of this means might be so satisfactory as to make the further treatment clear. On the other hand, it was to be observed that in a puzzling case Dr. Addison thought it an error on the right side (for an error it proved to be) to employ the remedies for peritonitis. The few leeches which were applied in the second case gave relief; but he, nevertheless, thought they were unnecessary and undesirable. It was by no means impossible for such means, by the temporary benefit they produce, to betray the practitioner into their repetition, with ultimately disastrous consequences.—*Lancet*, Nov. 19, 1870.

HOSPITAL NOTES AND GLEANINGS.

Cases in St. Bartholomew's Hospital, with Clinical Remarks, by Dr. ANDREW. *Aneurism.*—On examining a patient who was the subject of an aneurism situated in the left half of the chest, Dr. Andrew expressed the opinion that a considerable thoracic tumour in that situation inevitably causes obstruction of the thoracic duct. He had heard Professor Turner, of Edinburgh, express the same opinion; and had himself on two occasions endeavoured to inject the duct in similar cases, and found it completely closed at the site of the tumour. And he suggested that the obstacle thus presented to the supply of new material to the blood might have at least a share in inducing the well-marked cachexia which patients suffering from aneurism often present.

Suppuration without hectic.—Dr. Andrew drew attention to the absence of any symptom of hectic in a patient in whom a purulent discharge was being continuously evacuated by expectoration from the right pleural cavity, the patient being also the subject of pneumothorax. He said that hectic is by no means a necessary accompaniment of even profuse suppuration. If, however, pus, or even mere serous fluid, were confined in a cavity, or ceased to be of laudable quality, a constitutional effect would at once be found to ensue. With reference to this subject one of the house-physicians who was present said that a patient of Dr. Harris's had been recently tapped for a suppurating hyatid of the liver, and that the fluid, having accumulated at the rate of a pint a day, had been removed by occasional subsequent tappings. At first the patient exhibited a most voracious appetite, and appeared to suffer no ill effect from this profuse discharge; but on a certain day, her appetite failing, she refused her large allowance of food, and in the course of a few hours her temperature rose, she became hectic, and daily

increasing exhaustion caused death in ten days.

Sequelæ of exposure to the sun.—G. B——, aged thirty-eight, a patient in one of Dr. Andrew's wards, lay from about 11.30 to 12.30 of Sunday morning last on the grass of an open field without his cap. When he rose to his feet he felt giddy, and had sensations of swimming and throbbing in the head. He travelled home by rail, a distance of a few miles, and lay on the sofa for the remainder of the day, without tasting food. On the following morning he went early to his work, taking with him his breakfast, which, however, he was unable to touch. In the course of two or three hours the giddiness and throbbing in the head, to which had been superadded a severe pain extending down the spine from the root of the neck to the loins, became so severe that he could scarcely keep his feet; and he applied for admission into the hospital. His temperature was found to be 100°.6 Fahr. He was ordered to bed; ice was applied to the head, and a mustard plaster to the loins. This latter application was followed in about twenty minutes by a cessation of the dorsal pain; and on the following morning the patient expressed himself free from giddiness and throbbing. When last seen, four days after the appearance of the symptoms, he said he felt well, but his manner was somewhat tremulous.—*Lancet*, Aug. 6, 1870.

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Supposed Case of Acute Tuberculosis in Guy's Hospital, with Clinical Remarks, by Dr. Wilks.—On the occasion of a recent visit to this hospital, we saw a young woman about twenty years of age, who had been admitted three weeks previously. Her sobs and her manner generally indicated that she was in a highly hysterical condition. Dr. Wilks said that ever since her admission her temperature had indicated a state of pyrexia, but that she had exhibited no symptoms either of local inflammation or specific fever; and that whenever a high temperature was thus maintained for a considerable time, without the development of any other symptoms, it indicated the existence of acute tuberculosis. He had not been able to verify his opinion in this case by a physical examination of the patient, because she complained of such acute hyperæsthesia of the chest that percussion was impracticable, and directly he applied the stethoscope the breathing always became so rapid and shallow that no reliable observation could be made. But there were other signs which, in his opinion, lent confirmation to his diagnosis. These were, the patient's regular features, white regular teeth, and well-formed frame—all of them features of tuberculous temperament; and falling off of the hair; and her hysteric condition. Ever since a striking incident had called his attention to the subject at the time he was clinical clerk, he had noticed the frequent existence of hysteria and phthisis. For three months the late Dr. Addison had, out of sheer disgust, passed by the bed of a girl who was in so highly hysterical a condition that he had found it impossible to make a careful examination of her state. One day a student, who had remained behind to listen to her chest, remarked to Dr. Addison that he supposed the case was one of phthisis, as he had heard sounds indicative of a large pulmonary cavity. Dr. Addison replied that there was nothing the matter with the patient but hysteria; but, on the student insisting that there was a cavity at the left apex, he listened for himself, and found that such, in fact, was the case.

Speaking of the relation of pyrexia to local disease, Dr. Wilks added that he did not believe that when a local disease followed in the wake of fever it held to it the relation of a consequence; for example, when people spoke of fever terminating in phthisis or some brain affection, it might always be taken for granted that the antecedent fever had been the pyrexia proper to tuberculosis in the one case, or meningitis in the other.—*Lancet*, Dec. 10, 1870.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

To Subscribers.—In making up the Library Department of the News for Dec. 1870, an index for the *Diseases of the*

Spine and Nerves was prepared and set in type, as well as a table of contents. As one was little more than a duplicate of the other, however, it was thought that subscribers would prefer to have the space occupied by the Index filled with other matter. The Index was therefore cancelled, but reference to it in the Table of Contents was, by an oversight, allowed to remain. Subscribers in binding the Library for 1870 will therefore understand that the work is *complete* in the form in which they have received it.

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Antiphlogistic Value of Ergot.—Dr. Jacobi holds (*Medical Record*, Oct. 1, 1870) that ergot acts through the nervous system, and especially through the sympathetic, upon the unstriped muscular tissue under its control. Thus it is that ergot produces its peculiar effect upon the muscular tissue of the uterus, the unstriped fibres of the bladder, the muscular layers of the intestines, and especially upon the muscular coat of the bloodvessels. Its power in diminishing the size of the bloodvessels is manifest from its value as a hæmostatic; and it is of this power we have to speak in considering its antiphlogistic effect.

This effect is noticeable in fevers generally, and particularly in fevers of the intermittent type. It is an established fact, in my opinion, that many cases of obstinate intermittent fever will, when no longer benefited by quinia or arsenic, still be benefited by the action of ergot.

Dr. Jacobi states that he has given a mild preparation of ergot with a uniformly beneficial effect in many cases, not uncommon in women and children, of spinal meningitis resulting in pain, slight fever, occasional convulsions, partial or total paralysis. He has given it advantageously in the first stage of the so-called infantile or dental paralysis dependent upon congestion of the spinal cord. The persistence of the disease he attributes to dilatation of the bloodvessels, and he gives the ergot to effect their contraction. In cases of chorea minor, not connected with rheumatism, but with pain in some portion of the spinal column, ergot is often serviceable in removing the symptoms.

Dr. Jacobi uses large doses, as two drachms (to a child) of Squibb's fluid extract in the day, or from four to seven grains of Bonjean's ergotine. When its use is to be long continued, for chronic hemorrhages, etc., he gives commonly about a scruple of the ergotine, daily to an adult, and to a child in proportion to age. He has never seen any of the symptoms of so-called ergotism, whether of the spasmodic or gangrenous form, nor has he any fear of it resulting from the use of ergot in this dose.

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Large Doses of Chloral.—Dr. James Rodman states (*The American Practitioner*, Oct. 1870) that a nurse gave one of his patients, who was under treatment for insanity, in order to induce sleep, 270 grains of hydrate of chloral, which produced sleep for eighteen hours, without any alarming attendant symptoms.

A case is reported (*Medical Times*, Oct. 15, 1870) of a female nurse in the Philadelphia Hospital, who took 460 grains of chloral. It produced deep sleep, her respirations were 35—heavy and stertorous; pulse 140; face flushed: extremities cold and livid. The symptoms resembling those produced by an over-dose of opium. She was supposed to have taken that drug, and was treated in accordance with that supposition. She entirely recovered, when she stated she had taken some medicine from a vial for the relief of headache, and it was ascertained that the medicine was a solution of chloral.

It is stated in the *Lancet* (Nov. 26, 1870), that as much as 160 grains of the hydrate of chloral was lately given by mistake in one dose to a middle-aged man in one of the London hospitals. Some alarm was felt, but no disagreeable symptoms occurred; the man slept well, and no unpleasant effects resulted.

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Enlarged Spleen.—Mr J. G. Jay records (*Baltimore Med. Journ.*, Oct. 1870) a case of this in a negro man, æt. 28. The weight of the spleen was 9¾ pounds; its length 16 inches; greatest breadth, 11½ inches. It was lobulated upon the right margin; the fissures, 4 in number, were from one to two inches in depth.

Death from Chloroform.—In the *Boston Medical and Surgical Journ.* for Dec. 15, 1870, there is recorded a case of this occurring in a man aged 40 years, who had had chloroform administered by one of the ablest surgeons of that town, preparatory to an examination.

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Death from the Inhalation of Ether.—In the number of the *Boston Medical and Surgical Journ.* for Dec. 8, 1870, there is reported by Dr. WALTER BURNHAM, of Lowell, a case of "death from the effects of sulphuric ether," in the opinion of the editor "the result of an overdose." The operation was an amputation of the thigh for a gunshot wound; an ounce of ether was administered on a small napkin in a bowl, which was placed over the face, and one or two drachms were added every two or three minutes. In about ten minutes anæsthesia was induced, and the ether suspended; slight sensibility returning the ether was renewed with the desired effect, and again suspended. The operating surgeon then ordered the napkin to be reapplied with a drachm of ether freshly poured upon it. After one or two inspirations the patient ceased to breathe.

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Surgeon-General's Report.—From the annual report of the Surgeon-General for the year 1870, we learn that "while the rate of mortality from wounds and injuries among the *coloured troops* agrees with that among the *white troops*, their rate of mortality from disease alone is nearly double.

The printing of the medical volume of the first part of the medical and surgical history of the war is near completion. The peculiar value which the surgical data of the late war have acquired in consequence of the measures taken to trace the ulterior results of the more important cases cannot be overestimated.

"There has been a very steady and uniform increase in the various collections of the Army Medical Museum."

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College of Physicians of Philadelphia—MÜTTER Lectureship.—This position is now vacant. Applications for it are hereby invited, and may be made to Dr. S. D. Gross, S. E. corner 11th and Walnut Sts., Chairman of the Committee on Lectures. Information in regard to the duties, compensation, &c., may be obtained of

JOHN H. PACKARD, M.D.,
Secretary of the College,
1928 *Spruce St.*

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College of Physicians and Surgeons of New York.—Prof. WILLARD PARKER has resigned the chair of Surgery in this institution, and is succeeded by Prof. Markoe. Prof. John T. Metcalfe also retires from the chair of Clinical Medicine.

—

Virginia State Medical Society.—The first meeting of this society was held at Richmond, Va., Nov. 2d, 1870. The opening address was made by the president, Dr. R. S. Payne. He spoke at some length on the importance and objects of the organization.

On motion of Dr. W. W. Parker a committee was appointed to petition the Legislature for an act of incorporation.

On motion of Dr. F. Horner it was resolved to invite the members of the county and town medical societies to co-operate with the State organization.

And, on motion of Dr. Fauntleroy, a committee was appointed to memorialize the Legislature upon the establishment of a board of medical examiners, and to petition the General Assembly to pass a law authorizing liens on property to secure medical fees.

Reports were ordered to be made, at the next annual meeting, on the epidemics of the three divisions of the State—one for the tide-water district, another for the country lying east of the Blue Ridge, and a third for the Valley. Two Fellows were appointed to read essays at the subsequent meeting of the Society, upon subjects to be chosen by themselves.

The Society adjourned to meet in the city of Lynchburg, at the call of the Executive Committee.

FOREIGN INTELLIGENCE.

The After-Treatment of Cataract.—Mr. HAYNES WALTON, in a clinical lecture on cataract (*Med. Times and Gaz.*, Dec. 3,

1870), recommends the following after-treatment in cases of extraction :—

The very first act after the operation should be to close the eyelids with a couple of strips of court-plaster, about an inch and a half long and a quarter of an inch wide. This insures adaptation of the wound, and supports the corneal flap. Besides this, the atmosphere is excluded, and the eye is rested. It is the simplest appliance by which the eye can be kept closed, and such closure accomplishes all that can be done for the wound without disadvantage. The tears and the aqueous humour readily escape, because some portions of the edges of the eyelids are uncovered. Bandages and compresses of all kinds are injurious. They are hurtful in proportion to their action. All pressure, beyond that which is naturally produced from closing the eyelids, must tend to be prejudicial, and, at times, to be positively damaging. Again, whatever keeps the eye hot must be bad—whatever soaks up the secretions is objectionable. I am well aware, from personal observation, that some surgeons pack the eye with cotton wool or charpie, and subsequently apply a bandage. The system is very like the French method of treating a stump after an amputation. It is notorious how a French surgeon packs and bandages until the limb has pounds of material over it. I fully believe that my plan insures the highest attainable result that can be reached.

Whenever it seems necessary to protect the eye from blows from the patient's own hands, a stiff square shade, reaching from one temple to another, padded where it touches the head, and kept in position by an elastic band, will suffice. Calkin's eyeshade answers the purpose very well.

I believe it to be important that the patient be well fed, and therefore I allow him a full diet. Of course, he is carefully fed by the nurse, and does not make any exertion. It is a mistake to prescribe liquid food under the idea that chewing is hurtful to the eye, for in man the muscles of mastication cannot in any way influence the eyeball. It is different in most of the lower carnivora.

From day to day the corners of the eyelid and the cheek should be carefully cleansed. The patient should be kept in bed for the greater part or the whole of the week, but not necessarily between the sheets. When the bed is left, there is always a risk of imprudent acts.

When seven clear days have passed without unfavourable symptoms, success is pretty certain, and the plasters may be removed after they have been thoroughly softened with warm water. Then I try the sight by putting the patient's back to the light, and guarding the eye while he looks at something held before him. At the same time I endeavour to ascertain whether the cornea has healed. If the chambers of the eye be filled with aqueous fluid, union must have taken place. When everything is satisfactory the plasters need not be reapplied, but if otherwise, they are required. There may be simply delay in the healing, in which case the eyelids require to be closed as much as at first.

The pernicious practice of opening the eye a few days after the operation cannot be too strongly deprecated. The examination is quite useless if the eye be doing well; if otherwise, it is certain to aggravate any evil, and in no instance can it disclose symptoms for guidance more certain and more valuable than those of the patient's sensations and the state of the eyelid. A red and puffy eyelid is a sure indication of an inflammatory state of the eyeball, with an absence of proper repair in the corneal wound. Besides this, the angle of the cheek gets œdematous.

This after-treatment, which may be said to be purely mechanical, is really all that can be done for a patient; and when the cornea does not heal kindly, the case is never perfectly successful, do what you may, and in most instances the eyeball is somewhat damaged, and only an imperfect result as regards vision is obtained. The very best sight is never got except the pupil be round and central, or nearly central. It is not enough for a patient to be able to read the smallest type under certain favourable conditions of light and position; he may do this with an irregular and displaced pupil. I want more; I wish him to be able to face a bright light

without distress, and to get the light admitted to the centre of the retina, for both of which the pupil must be of the natural size, or nearly so, and central.

When any unfavourable complication ensues which destroys all chance of primary union of the cornea, whatever depresses the patient will very materially tend to lessen the prospect of his recovering any degree of sight. He is sure to be enfeebled by the adverse condition of the eye, and the constitutional symptoms are often severe. It may be said, in general terms, that only those measures which tend directly to relieve pain and to soothe are admissible. With the least chance of saving the eye, the therapeutic measures most to be relied on is rest to the wounded part—that is, the eyelids must be again plastered. This may be necessary for weeks. Many an eye is lost because this is not attended to. All else is in vain if this be neglected. I believe its simplicity is the chief reason why this, my practice, is not more generally followed. It leaves nothing for meddlesome fingers to do. While in the first week I always plaster up both eyes, in the secondary treatment, to which I now allude, I close only one.

When both eyes are equally affected with blindness, only one at a time should be operated on for extraction, and the first should be allowed to recover before the other is touched. Both eyes may be operated on at the same time for solution.

—

New Operation for Erectile Tumours.—At a recent meeting of the Belgian Academy of Medicine, M. Michaux gave an account of a new mode of procedure he had adopted for the treatment of erectile tumours. During the thirty-four years that he had been engaged teaching clinical surgery at Louvain, he has had abundant opportunities of putting the various modes of treatment that have been recommended, from time to time, into force, and has communicated the results to the Academy. The present plan, which he regards as preferential to all others, consists in a combination of Guersant's *cautérisation actuelle parcellaire* with the employment of the perchloride of iron. He had heretofore frequently had recourse to this mode of cauterization, and found himself obliged to have recourse to the perchloride in order to arrest the hemorrhage which ensued on the cauterization. He soon, however, remarked that this application contributed greatly to the cure of the tumour, and therefore he resorted to its use in cases in which the cauterization gave rise to no bleeding.

"At the present time this is the way in which I treat erectile tumours, whatever may be their description, seat, or size: With one of Guersant's needles, heated to whiteness, a track is practised on the tumour, either directly or by piercing the skin at a certain distance from it. Several needles may be placed in the same track, but that is not indispensable. As soon as the cautery is withdrawn, I substitute for it the tents of charpie, soaked in perchloride of iron, and prepared beforehand. I thus plug the aperture until no more blood flows, and leave the charpie *in situ* until suppuration is well established. I then replace these tents by others, taking care to increase the detachment, and repeat this dressing every day, or every other day, according to the amount of suppuration. In this way I destroy entirely the erectile tissue, invading it in every direction with the charpie soaked in the perchloride. If the tumour is large, several punctures may be made; and if cutaneous arterial spots (*taches*) persist, they may be painted with the perchloride or cauterized by Guersant's needle."

M. Michaux observed, in conclusion, that the practice was a certain one, unattended with danger, and easy of execution; while the same results are not obtainable either by using the caustic alone or by the injection of the perchloride—this last being sometimes dangerous by producing gangrene.—*Med. Times and Gaz.*, Nov. 12, 1870.

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Hypodermic Treatment of Syphilis.—At one of the recent meetings of the Lyons Medical Society, M. Diday detailed the results of a trial of the hypodermic treatment of syphilis, which he has made in twelve cases. Although so few in number,

these experiments, conducted by the hand of such a master in all that relates to syphilis, are more important than a far greater number would be, detailed by persons of no authority. He employed the syringe and solution recommended by Liégeois, this last consisting of distilled water, 45 grammes; corrosive sublimate, glycerine, of each 10 centigrammes. Two, and sometimes three, injections were practised daily, the mean quantity of sublimate introduced each day amounting to 7 or 8 milligrammes. The back is the preferable region for the operation, as the pain is complained of less there; but when the patients inject the solution for themselves, the sides of the chest or the anterior and external parts of the thigh should be selected, alternating these regions, so that the punctures do not succeed each other too rapidly or approach each other too closely. M. Diday felt very well disposed towards the remedy, as he believes that in it we have an opportunity of bringing the specific into action in a far more direct manner than in ordinary modes of treatment. As cases for trial, he selected patients who were somewhat severely affected, and in whom the disease had resisted the ordinary measures. After supplying the chief details of the twelve cases, M. Diday observes—

"These results, incoherent and even contradictory as they seem at first sight, cause me, I must admit, great embarrassment in pronouncing an opinion on this new method. In fact, there is no occasion to pronounce any positive opinion on a remedy which has so recently made its appearance. At first, one is struck and seduced by the promptitude of some of the cures which it effects, only to fall again into a state of doubt on observing it powerless in other analogous morbid conditions, or even in such as are less serious in appearance. We must not allow this doubt, without further information, to pass into discouragement. Deeper researches, instituted while varying the formulæ, and only injecting every two or three days, in order to prolong the time necessary for the cure, and perhaps by adding the employment of other agents, etc., will, it is to be hoped, lead to more constant results and less vague conclusions concerning the degree of power of this mode of treatment and its special adaptation to certain forms of syphilis. Above all things, we ought, in this channel of absorption as in others, not to limit ourselves to the injection of a mercurial preparation. As is so well known since the able demonstration of our legislator in therapeutics, Ricord, we should, according to periods or *age* of syphilis indicated by this or that lesion, administer mercury to one patient, iodine to another, and a combination to a third. Beyond this rule there is no safety."

M. Diday believes that great advantage is derivable from the injections in the squamous form of syphilides, which is sufficient to prevent our neglecting it as a remedy. He agrees with M. Liégeois and others that it is not only useless, but mischievous (by consecutive ulceration of the punctures) in the ulcerative forms of syphilis. A very great advantage of the hypodermic method is, that it saves the digestive organs, for under it none of those affections of the stomach and intestines, that so often interfere with treatment, occur. In none of M. Diday's patients was the slightest mercurial affection of the mouth produced.—*Med. Times and Gaz.*, Sept. 3, 1870.

—

Radical Cure of Hydrocele by the Seton.—Mr. Henry Smith calls attention (*Med. Times and Gaz.*, Nov. 12, 1870) to the ancient practice of Pott as having been attended with good success in his hands; in about thirty cases only two suffering from acute inflammation of the sac following the operation, in one of which it resulted from taking a long walk immediately afterwards. Pott's treatment consisted in the introduction of "ten or twelve strings of candlewick cotton," the fluid in the vaginal sac having been previously drawn off by a trocar and canula. He put his patient to bed, and purged him. Mr. Smith remarks that this plan was without doubt unnecessarily severe, and the mode he adopts is simply to puncture the tumour with a common suture needle, armed with a single thread, and having brought the thread out a dis-

tance of one or two inches from the point of entrance, it is disengaged from the needle, and the two ends are lightly tied together. He does not tap the hydrocele first, as Pott recommended, for if a pretty good sized needle be used the fluid readily drains away. The patient may, and usually does, go to his ordinary occupation, and at his visit in forty-eight hours the part is considerably swollen; or if this be not the case, inflammation may be excited by moving the threads. In the majority of cases, the threads may be removed in from eight to ten days. In only one instance has Mr. Smith met with a sufficient want of inflammatory reaction to bring about a cure.

—

Simulation of Hip-Joint Disease by Suppuration of the Bursa over the Trochanter Major.—Dr. Macnab gives (*Lancet*, Nov. 12, 1870) the notes of two cases of this disease, which present features of interest. In one, a strumous boy, aged eleven, received a blow on the trochanter, which produced pain and swelling, the former disappearing, the latter remaining under treatment. Rest, blisters, and iodine externally, and phosphate and iodide of iron with cod-liver oil internally, failed to effect any improvement; and the limb simulated in a marked degree the first stages of morbus coxæ. There is, however, no pain on pressure, or on striking the knee or foot upwards. A splint was applied, and the case looked a doubtful one, originating in periostitic inflammation, and likely to end in caries or necrosis. Two months afterwards, however, the swelling over the hip suddenly became painful. Suppuration occurred; the abscess burst, and speedy recovery followed. In the second case, a married woman, aged twenty-two, without previous injury, became sensible of severe pain in the left hip over the trochanter major. The pain increased and swelling occurred. Opinions were divided as to the nature of the case, some regarding it as one of deep-seated abscess, the result of periostitic disease in the neighbourhood of the trochanter major and upper part of the femur, others holding it to be an undoubted instance of morbus coxæ. She was treated with counter-irritation, chalybeates, and cod-liver oil. The hip-joint fixed, but not painful on pressure; slightly flexed on pelvis over the trochanter major, and involving the upper third of the thigh, was a large, tense, acutely painful swelling, and great constitutional disturbance. After deliberation, Dr. Macnab opened the abscess, from which a pint and a half of healthy pus flowed, and recovery soon followed.

—

Cancer of the Pancreas, simulating Hepatic Abscess.—Mr. Jayaker, Assist.-Surg. Huttee Singh's Hospital, Ahmedabad, records (*India Med. Gaz.*, Nov. 1, 1870) the following interesting case of primary cancer of the pancreas which is not altogether an uncommon disease, but the circumstances under which it presented itself in this case, were more than likely to lead to a false diagnosis. A large fluctuating tumour occupying the right hypochondrium, epigastrium, and a part of the left hypochondrium, attended with anæmia, and the characteristic diarrhœa of an abscess bursting into the intestines, is strongly suggestive of the existence of a hepatic abscess.

Peera Hakeemjee, an anæmic Fakeer, was admitted into the hospital on the 30th of March, 1870, with the above symptoms. The tumour extended more to the left, and on exploring with the needle only a few drops of blood escaped, which were the only signs against the supposition of an abscess in the liver. He was treated with stimulants and tonics. but he died, exhausted, on the 1st of April.

On making a post-mortem examination, a large cancerous tumour of the pancreas, apparently about 5 pounds in weight, was found; the liver was quite pushed into the right thoracic cavity from pressure. The other organs were normal, excepting that they were anæmic, and had suffered from the pressure of the tumour.

—

Temperature in Hæmatemesis.—Dr. Edward Long Fox states (*Med. Times and Gaz.*, Nov. 5, 1870) that in hæmatemesis the thermometer is, to a certain extent,

a guide as to the pathological condition. Gastric hemorrhage will always be accompanied by a temperature more or less elevated if it proceed from ulceration that depends on acute or chronic catarrh of the stomach. A normal temperature may, however, coexist with rather extensive ulceration of the mucous membrane connected with cancer of the stomach.

—

Cardiac Murmurs in Chorea.—The murmur which is not unfrequently heard in choreic patients, Sir William Jenner affirms (*The Lancet*, Nov. 5, 1870), is a mitral regurgitant murmur, due to irregular action of the papillary muscles, sometimes accompanied by irregular contraction of the heart itself. Thus cases are met with in which there is irregular action of the heart with an occasional murmur, or irregular action with a constant murmur, or regular cardiac action either with a constant or inconstant murmur; and in all these cases the murmur, and irregular action when present, disappear either shortly before or shortly after the cessation of the choreic movements of the voluntary muscles. Murmurs first detected during a choreic attack may remain after its subsidence, but in these cases there has been at some time inflammation of the endocardium.

—

Oil of Peppermint as a Local Anæsthetic.—Dr. A. Wright writes to the editor of the *Lancet* (Nov. 19, 1870), that "a few years ago I became acquainted with the fact of the natives [Chinese], when suffering with facial neuralgia, using oil of peppermint, which they lightly apply to the seat of pain with a camel-hair pencil. Since then, in my own practice, I in the same way frequently employ oil of peppermint as a local anæsthetic, not only in neuralgia, but also in gout, with remarkably good results; indeed, the relief from pain I have found to be almost instantaneous."

It is worthy of note that some Chinese pharmaceutists in San Francisco and New York have been selling a remedy for neuralgia, which has gained some repute. It is a liquid put up in very small vials, holding about half a drachm each, which are sold at an exorbitant price. The liquid has a strong smell of peppermint, and is in all probability the oil of that plant.

—

Koumiss.—This is prepared from mare's milk, a beverage which the nomadic tribes of Bashkirs and Tartars drink in a state of fermentation. Dr. Victor Jagielski, late a physician of the Prussian army, has been led to consider, in common with many physicians of Russia and Germany, that the popular belief of these people, which ascribes their exemption from consumption, bronchitis, and other diseases to the almost exclusive use they make of koumiss, has a considerable foundation in fact. One of the first persons to direct attention to koumiss as a dietetic and therapeutical agent was a Dr. Grieve, F.R.S. Ed., who held the post of physician to the Russian army. The best koumiss is manufactured in the government of Orenburg, especially on the large estates of Istchoff, in the village of Kilimow, in the district of Beleber.

Koumiss institutions, supported by the Imperial Government of Russia, are now existing in Samara, under Dr. Postinkoff; in Odessa, under Dr. Levenson; and in Moscow, under Dr. Stahlberg. These establishments are preparing their koumiss from mare's milk; but within the last ten years institutions have been founded nearer to the centre of Europe, where koumiss is prepared from cow's milk, as in Warsaw, under the management of Dr. Przystanski. In St. Petersburg, and many other towns of European Russia, there are also institutions where koumiss is prepared from cow's milk by workmen brought expressly from Tartary, as well as in Charlottenberg, near Berlin, and in Ottenstein in Saxony.

Drs. Lersh, Schwepp, With, and Stahlberg, give a favourable opinion as to its effects as a remedy. When a Russian physician advises his patient to take koumiss, the latter at once conceives the idea that he suffers from consumption; and in fact the belief in the power of koumiss in this disease is said to have taken such root, that patients use it of their own accord, without any appeal to medical advice.—*Lancet*, Nov. 26, 1870.

Death from Chloroform.—In the number of the *Medical Times and Gaz.* for Oct. 8, 1870, there is recorded a case which occurred at Yokohoma. The chloroform was administered for the reduction of dislocation of the shoulder-joint.

—

Smallpox.—A severe epidemic of this disease is now prevailing in London, and is increasing. During the fortnight preceding the 26th of November last, eighty-five deaths from it occurred, and the Registrar-General states that so many weekly deaths from it have not occurred since April, 1867. In the No. of the *Lancet* for December 10th it is stated that the deaths from it during the preceding week had risen to 60, the highest number returned in any week since June, 1863.

It behooves the authorities in this country to take every possible precautionary means of preventing its introduction here, and should it reach us, to prevent its spreading, by general vaccination and re-vaccination. The importance of this last cannot be over-estimated.

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Deaths from Snake-bites.—It appears from a statistical table in the *Indian Medical Gaz.*, Nov. 1, 1870, that 11,416 deaths from snake-bites occurred in British India during the year 1869, or one death in every 10,000 inhabitants.

—

Professor Skoda.—We regret to learn that owing to impaired health Professor Skoda has determined on resigning his chair in the University of Vienna.

—

Mixed Medical Classes.—We have already noticed (Number for December last, page 177) the efforts at present being made for the instruction of male and female medical students in the same classes, and the attempt is so repugnant to our sense of decency that we are reluctant to again recur to it, but a recent discussion at the conjoint meeting of the Managers and Staff of the Royal Infirmary of Edinburgh, places the subject in so strong and disgusting a light that we may be excused for saying a word more in regard to it, for we are persuaded its advocates have not sufficiently reflected on the results which must inevitably follow.

At the meeting alluded to Prof. Lister stated "that he had just been removing the testicle from a patient, in which he had necessarily to expose the penis, and operating on the anus of another, and that he felt it would be impossible in decency to do these things in the presence of young ladies and gentlemen. One of his dissenting colleagues expressed his surprise at this statement, because he was satisfied such procedures could not possibly excite the sexual instinct; and a second followed up the argument by quoting an instance within his own experience of a daughter who passed the catheter for her father without having any sexual feelings excited whatever! Professor Lister protested that it was a feeling of disgust which decent men felt." His dissenting colleagues could not understand this at all; and the conclusion is, therefore, forced on us that their sense of decency is extremely obtuse or entirely wanting, and it would be as vain an effort to make them comprehend what constitutes modesty as it would be to endeavour to convey to a person born blind an idea of colours.

The Bishop of Manchester recently remarked at the annual meeting of the Manchester Society for promoting the higher education of women: "If any one looked upon a school of anatomy, containing mixed classes of male and female students of from eighteen to twenty-five years old, as an edifying spectacle in the midst of modern civilization, then their notions of what was right and becoming were different from his."

"Dissection," the editor of the *Lancet* (Dec. 10th) justly remarks, "is not a pleasant occupation at any time, and it is a very repugnant task to many students; but for a girl to be so occupied amid a number of male students seems to us, in one word, *nasty*."

And again, "if the male students feel this while the lady students do not, all we can say is that the former seem to us to manifest a far more delicate appreciation of what is modest and becoming than the latter."

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HENRY C. LEA, Philadelphia.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Incontinence of Urine.—By T. CLIFFORD ALLBUTT, M. D. Cantab., Physician to the Leeds General Infirmary.

GENTLEMEN: A young woman has just been cured and discharged from ward No. 10, to whose case I shall now direct your farther attention.

The malady under which she was suffering is one of a very distressing kind, and is by no means rare; yet it is one which, like some other functional disorders of the uro-genital system, receives less than its proper share of attention, chiefly because the patients labor under a double shame, which compels them to secrecy. As in spermatorrhœa, for example, so in the kind of incontinence of urine which closely resembles it, there is a consciousness of pollution which makes it doubly difficult for them to speak freely on a function which under any circumstances is not easily discussed. For the same reasons I contented myself with pointing out the young woman to you in the ward, and deferred any farther remarks upon her condition until I had the opportunity, which her absence now gives me, of handling it freely. Her history is as follows:—

Louisa T——, aged eighteen, has suffered from incontinence of urine at night for many years, as long indeed as she can remember. The recurrence is rather variable; sometimes she may pass a night or two nights without wetting her bed, but this relief is rare; as a rule, on awaking in the morning she finds her bed wet, and she has reason to suppose that expulsion of urine takes place on many nights more than once. This disorder is not only very

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distressing in itself, but is very injurious to her in her calling as a domestic servant. She came to us in despair on losing her last situation, scarcely hoping to be cured, but driven to seek some new remedy for a disorder which caused so great annoyance both to herself and all those about her. These facts were told to me in private by the girl and her mother when they came first to the hospital. Beyond the nocturnal incontinence I heard but little complaint of her health. The girl had certainly somewhat of the dull and downcast look we see in many epileptics, but she had not suffered from epilepsy. Her menstrual functions were normal. The family history was very imperfect. Every effort had been made to prevent the nightly discharge, but in vain. As in all such cases, the patient had avoided liquids during the latter part of the day, was most careful in emptying her bladder before retiring to bed, and very frequently she submitted to be called up once or twice during the night to pass her urine. In spite of these precautions, which were as fruitless in her case as in others of the same kind, the involuntary ejaculations still occurred during sleep. She believes that she generally loses urine twice during sleep—first about midnight, and the second time early in the morning. It does not appear, however, that she is a very sound sleeper, for her slumbers are easily broken when her mother awakens her for the purpose of natural relief. The long history of the case prevented the suspicion that any such irritants as worms, fissure of the anus, intra-vesical ulcers or calculi, were present; nor, on examination, could any such causes be ascertained.

Such is one example of a malady which is tolerably familiar to those who follow my out-patient practice, where we have generally five or six cases of it on our books. Children are the most common subjects of it; but not rarely it abides until early adult life, as in Louisa T——.

Now let us compare with the case I have just related to you the following, the notes of which have been placed in my hands by Mr. Drake: Catharine J——, aged twenty-two, a domestic servant, was admitted into my wards during the summer vacation, for general nervous debility. When admitted we were made aware that she also suffered from incontinence of urine. By day and night alike her water would dribble almost imperceptibly from her, issuing from the bladder in drops or jets so small that they defied the precaution of using the vessel. If she coughed or made other like efforts, more considerable quantities would suddenly escape from her. The incontinence was no worse at night, but was rather less severe, unless by lying on her back she threw the weight of the contents of the bladder upon the neck of it; in which case she had discovered that the incontinence became excessive.

My last patient, Louisa T——, was, as you remember, treated and cured with belladonna. For Catharine J——, belladonna was never prescribed, but liquor strychniæ. In a few days she was thus enabled to hold her water for half an hour, and in a week she recovered almost complete power over the bladder. You will see at a glance, when the two cases are set side by side, how different they are, and how different are the means needed for their respective cure. If we seek a parallel to the case of Catharine J——, we find it in a case of incipient paraplegia now under my care in No. 10: this woman tells us that sometimes her urine escapes from her by day, and that she is always obliged to hasten to the closet the moment a sensation of micturition is felt, or she would find herself overtaken.

But in other cases of paraplegia you may remember that retention of urine is seen, and we have the fear of this dangerous event always before us in the continued fevers. In these cases incontinence, diurnal and nocturnal, may also be seen; and it does not then signify a continual escape of the secretion as fast as it is formed, but rather signifies overflow—the bladder being filled beyond its capacity. A careless practitioner, who is unaware of this, and who is not awake to the duty of percussing the bladder daily in such cases of fever or of palsy, may by the neglect of catheterism become responsible for the death of his patient. Here

the explanation is simple: the patient in fever is unconscious of the sensation which naturally calls him to micturate; in palsy he also wants consciousness, or he may want power in the muscular coats of the bladder.

If, on the other hand, we seek a parallel to the kind of incontinence seen in Louisa T——, we find it in the spasmodic ejaculations occurring in cases of incontinence of semen. It is a mistake to suppose that incontinence of semen occurs as a consequence of onanism only; it may be due to other causes, and occurs often enough in continent or married men. In both these latter incontinences we have the same element: a sudden spasm, with consequent emission. The fact of emission is of course an accident, the spasm being the primary element; and we find accordingly that in nocturnal enuresis spasm is made manifest when ever so little urine is present, and no doubt occurs at times when too little urine is present to make its effects very evident. You will see that this event then differs in no essential way from epilepsy. Like it, epilepsy tends to recur, in its earlier stages at least, by night; and if there be no secretion voided, it is merely because the muscles involved do not happen to be the continents of a secretion—a difference which is accidental only. Like it, too, nocturnal epilepsy is brought best under control by the use of belladonna.

Let us now consider what are the elements with which we have in all these cases, and in nocturnal incontinence especially, to deal. We have in the bladder two sets of muscular fibres—the one set called collectively the detrusor set, and the other called collectively the sphincter, the two sets being opponent. In addition to this, we have afferent and efferent nerves, connecting these muscles with the sacral plexus, and with a definite region in the spinal cord, which experiment and observation lead us to fix somewhere about the sixth dorsal vertebra, and there they are brought into relation by means of nerve-cells. Other fibres pass onwards to the encephalon, and establish consciousness of irritation, and also that regulating power over the actions of the bladder which endows us with the valuable power of voluntary retention and emission of urine. Supposing, then, that this machinery goes wrong, we have to seek the fault first in the structure of the bladder itself. Such faults do not, however, come under our consideration at present, as we are dealing, not with surgical matters, but with diseases of the nervous system. We shall, then, look beyond the bladder to its innervation, and any one of the following faults is possible: (1) There may be excessive irritation or irritability of the afferent nerves; or (2) this may be deficient. (3) There may be excessive irritation or irritability; or (4) this may be deficient. (5, 6) There may be one or other of these opposite states in the nerves communicating between the spinal and the encephalic centre. The efferent encephalic fibres exercise, I say, that moderating action upon the central spinal actions which between the medulla and the heart is called inhibitory; in the latter case the heart is regulated in obedience to the less complex variations of organic actions; in the former case the movements of the bladder are regulated in accordance with the more complex variations of animal actions. When a very powerful impression upon the encephalon paralyzes these fibres, we have at once that spasm of the detrusor which we may see in a schoolboy brought up to be whipped. If, on the other hand, the encephalon remaining unaffected, the whipping be upon parts supplied by the sacral plexus, we have excessive stimulation of the afferent spinal fibres, and the same consequent tendency to discharge of energy in the uro-genital system.[1] Worms, or fissure in the rectum, uterine disorders, gonorrhœa, phimosis, or ulcers, calculi and acid urine within the bladder, act in the same way. Paresis of controlling encephalic fibres has then the same consequence as excitement of afferent spinal fibres; in both cases the detrusor urinæ, by excitement or by permission, overcomes the sphincter.[2] Again,

[1] Ita, ut aiunt, solent impudici quidam invitam venerem vergis sollicitare.

[2] I should not of course advance these novel views unless I thought I had evidence in favour

if we have regard only to the local efferent nerves, we see that exhaustion of the spinal centre has the same result of instability as exhaustion of its encephalic ally and as stimulation of the afferent nerves. Onanism acts in this way, both in causing frequent daily micturition—*castus raro mingit*—and especially in allowing spasmodic emission of either urine or semen, when during sleep the tension of the weakened spinal centre is no longer reinforced by an active encephalon.[1] In paraplegia we often have both these causes at work. Communication may be broken between the encephalon and the lower cord in the first place, and the spinal centre may be weakened likewise, allowing of priapism, seminal and urinal emissions, and other evidences of instability, in which cases the incontinence is often nocturnal at the outset; or it may be palsied, allowing of the complete incontinence of flaccidity, both diurnal and nocturnal. It would seem that exhaustion of neighbouring centres in the cord may spread to the genito-urinary ganglia;[2] for many men who, like Alpine climbers, exercise the legs strongly, but occasionally, are liable to irritability of the bladder, and to nocturnal emission of semen, during the first days of their holiday. When enuresis is due to the removal in sleep of part of the inhibitory action of the encephalon, we have by day what is called continence; but this continence is often imperfect, the patient being obliged to micturate frequently, and to answer the call quickly. Many healthy persons, of nervous temperament, many women especially, have this degree of incontinence at night, although their resisting power by day may not be insufficient.

This irritability of the detrusor is generally or always accompanied with ineffectual spasm of the sphincter also; in the female bladder this is readily demonstrated, and in young boys, who suffer in the same way, the penis is usually half erect during sleep.[3] But in that form of incontinence which is seen in continuous dribbling, we have to deal with the opposite state in both sets of muscular fibres; for, although the urine of such persons is ever escaping from them, yet, on the other hand, they are incapable of projecting it far on a voluntary effort. Dribbling differs from spasmodic incontinence in this—that it occurs as well by day as by night, that the subjects of it are never able to project a strong stream, and that, unlike spasmodic enuresis, it frequently takes place on a sudden exertion like coughing. Many women who have borne children, and whose parts are relaxed, become unable to hold their water when coughing. These cases, and the similar debility we often see in young persons, as well as in those of advanced life, are susceptible of a good deal of relief from the use of strychnia, and also of ergot of rye, sometimes one drug and sometimes the other having the advantage.

The treatment of spasmodic or nocturnal enuresis is very different, and resembles closely that needed for seminal incontinence. Everything calculated to stimulate the afferent nerves of the sacral plexus must be avoided. The patient must avoid heating the nerves by taking care to lie on the side, and by the use of a mattress with light bed-coverings. It is right also, for the same reason, to prevent fulness of the bladder at night by abstinence from evening drinks, and by natural evacuations. In persons of this irritable or spasmodic habit, every eccentric cause of irritation to the afferent nerves—such as constipation, worms, uterine disorder, acid urine, and the like—must be removed; and, on the other hand, the tone of the parts must be restored by the systematic use of cold douches to the lower half of the spine. In bad cases a very small opiate or belladonna suppository acts like a charm in soothing the irritability. Es-

of them; but their proof did not form part of the present lecture.

[1] In such cases it is well known that, even in waking hours, a very slight additional irritation to the afferent (pudic) nerves will upset central tension, and cause seminal discharge.

[2] Dr. Handfield Jones, in the last number of *The Lancet*, has suggested this weakening of a nerve-centre by exhaustion of its neighbour. Careful clinical watching of such cases would be a kind of experimental physiology.

[3] Herein I must differ slightly from the recently published views of Dr. Burney Yeo (*The Lancet*, Oct. 22d, 1870).

pecially must belladonna be given also as a medicine during the day, or as a pill at bedtime. Children, as Dr. Fuller has shown, will bear belladonna in very large doses; and a little child suffering from nocturnal incontinence was pointed out to you on the last out-patient day whose malady remained untouched until we reached a dose of two grains of the extract at bedtime, when she found relief. Whether the belladonna be given at bedtime or as a daily medicine seems of little importance. Bromide of potassium, which seemed *à priori* a likely remedy, is quite useless. If you can add gentle local faradism to the cold douches, you will find great benefit arise from it; such, at least, was my own experience in two bad cases.

The general treatment needed in these cases is that needed in all persons suffering from instability of the nervous tissues; and as we sometimes find nocturnal incontinence in delicate, nervous children, often, moreover, associated with herpetic eruptions, seminal discharges, epilepsy, weakness of mind and temper either in themselves or in their near relatives, so we must never forget, by the use of our best "nervine tonic," cod-liver oil, of mild preparations of arsenic and of steel, and also of general hygienic measures, to restore that tone in which by nature they are deficient. In thus estimating your duty as physicians, gentlemen, I must, however, remind you that incontinence of urine very often depends on no constitutional habit, but on local disorders. In these cases the nocturnal incontinence is generally associated with more or less distressing diurnal irritation also. My surgical colleagues, and my friend Mr. Teale in particular, have, I believe, drawn your attention to the treatment required under these painful circumstances.

P. S.—Since the above lecture was delivered a very interesting and important note has appeared in *The Lancet*, by Dr. Thomson, of Peterborough. He was led empirically to recommend chloral as a remedy for nocturnal incontinence of urine, and apparently with great success. We have ample opportunities amongst our out-patients of trying this remedy; and if it answers in our hands as it has done with Dr. Thomson, it will supersede belladonna.—*Lancet*, Nov. 26, 1870.

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Clinical Remarks on Residual Abscess.—On the 10th of December, Mr. Paget operated at St. Bartholomew's Hospital on a girl who presented the novel features of a residue of obsolete pus in a cavity in the lower end of the tibia. On her admission, rather more than a year ago, with acute necrosis of the tibia, a long incision was made in the line of the bone, and a quantity of pus liberated from between it and the periosteum. Later, an attempt was made to take away the necrosed portion of the bone, but it was found to be too firmly fixed. In August last, however, Mr. Callender, in Mr. Paget's absence, succeeded in removing a large portion of the middle and upper thirds of the shaft. The wound healed well, but there still remained at the lower end of the limb one or two small openings leading down to some more dead bone, with a view to remove which Mr. Paget performed the operation in question. His incision disclosed one or two small sequestra, and the large cavity in the lower end of the shaft of the tibia which contained them was filled with thick mortar-like substance consisting of half-dried obsolete pus.

In remarking on this case, Mr. Paget explained that such cavities in bone usually become filled with a soft and vascular fibrous structure; but that, as in the case of abscesses elsewhere, the contained pus may, on the other hand, remain behind, and dry up into the inspissated substance called "obsolete pus," leaving the patient liable to a return of acute inflammation of the part, resulting in what he calls "residual abscess." In the present instance, for example, had not the small remaining portions of necrosed bone led to the exploratory operation, the patient's limb would in all probability have healed with every outward sign of perfect health, but yet inclosing a substance which, perhaps soon, perhaps after a term of years, would, under the influence of a decline in general health or some other exciting cause, have lit up acute inflammation, and produced another abscess. As an il-

lustration of this process, Mr. Paget referred to a patient whose case had already been mentioned elsewhere, but on whom a post-mortem examination has since been made. Twenty-four years before his death the patient was believed to have an abscess in the left iliac rigion, of which he was near dying. It was supposed by the two eminent medical men who attended him to have occurred in connection with disease of the cæcum. He remained in fair health for twenty years, and then, two years before death, another abscess appeared below the crural arch and in the loin. It was opened successively in both these places. When the patient at length died exhausted by the profuse purulent discharge which it maintained, the evidence of the post-mortem examination went to show that the first abscess had been caused by disease of the lumbar vertebræ, and that the second had been a residual abscess, formed about the remnants of the old disease.—*Lancet*, Dec. 17, 1870.

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Clinical Remarks on Stricture of the Œsophagus. By Mr. PAGET.—Two cases of stricture of the œsophagus, produced by the action of corrosive fluids which had been swallowed some time previously, came recently under the care of Mr. Paget, at St. Bartholomew's Hospital, and remained for a time in his wards, while, to prevent ultimate closure of the tube, the patients were instructed in the art of passing bougies through the strictured portions.

With reference to these cases Mr. Paget made some interesting remarks on the diagnosis and treatment of stricture of the œsophagus, in the course of which he explained his views of that particular form of stricture which is usually denominated "hysteric" or "spasmodic." It was, he said, the homologue in the pharynx or œsophagus of that want of harmony between the organs of speech and respiration which produces stammering; and appeared to depend on a want of perfect concert between certain involuntary muscles and muscles under the control of the will, which are designed to act in harmony. In the latter case the muscles of respiration do not act in time and unison with the organs of speech; in the former, instead of the normal contraction of successive portions of the upper part of the alimentary tract from above downwards, which transmits the food regularly from the mouth to the stomach, there occurs an unruly contraction of certain fibres, which, as long as it continues, bars the passage of food as completely as if some permanent obstruction existed. The degree of this contraction varied in different cases: in some it only compelled the patient to take his meals apart, or inconvenienced him whenever his attention was in any way directed to the act of swallowing; while, in others, it produced contraction so obstinate and complete that the maintenance of life by means of gastric digestion was wholly prevented. In those extreme cases recourse must be had to enemata; and, as in all other cases where nutritive materials have to be supplied to the body for more than three or four days by the introduction of food into the rectum, it would be found necessary to make use of something more than beef-tea and brandy, and, by injecting preparations containing fats, starches, sugars, and vegetable as well as meat juices, to supply all the ingredients which are contained in a natural diet, and are essential to the building up of the various tissues of the body. Of the fact that vegetable juices could thus be effectually introduced into the system, he had recently had very satisfactory proof in the case of a patient with whose nutritive enemata had been mixed some of the essence of water-cresses, proposed by Mr. Wyatt: at the end of a few days the patient had begged that the quantity of the essence might be diminished, because the flavour of that vegetable in his mouth had become so strong and so constant as to be extremely disagreeable. —*Lancet*, Jan. 7, 1871.

HOSPITAL NOTES AND GLEANINGS.

Cases under the Care of Mr. James Adams, in the London Hospital.—Mr. ADAMS pointed out instances of the following unusual injuries:—

Dislocation of the Right Os Innominatum.—This injury had befallen a Greek

sailor, ten weeks previous to admission, in consequence of a violent blow which fell upon the bone a little above the acetabulum. On admission the entire bone was found to move freely at the symphysis pubis anteriorly, and at the sacro-iliac synchondrosis posteriorly. A double spica bandage had been applied, and the patient kept at rest. At the time of our visit, a month later, the bone had become much less movable. There had been no symptoms of injury either to the pelvic viscera or to the hip-joint.

Fracture of the Epiphysis of the Crest of the Ilium.—A young man, twenty years of age, had been thrown down and kicked on the left hip. On admission a small wound was found below the anterior superior spine of the ilium, and a long, slender solid body was found to glide freely on the crest of the ilium, both when forcibly moved and during a deep inspiration. The sensation conveyed to the finger suggested that the contiguous surfaces of the loose body and the iliac crest were smooth and cartilaginous. There was no bony crepitus. A spica bandage had been applied, and the mobility of the severed epiphysis was becoming less.

In the early part of the afternoon Mr. Adams had removed, by Teale's operation, the leg of a man who had a large malignant ulcer of the heel.—*Lancet*, Dec. 24, 1870.

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The Estimation of Albumen during the Use of Diuretics.—The quantity of albumen in the urine of a patient who had been admitted into Middlesex Hospital with mitral disease, albuminuria, and some consequent œdema, was reported to have undergone a marked diminution. Dr. Murchison directed attention to the fact that, in estimating the proportion of albumen, the quantity of urine passed by the patient must also be taken into consideration; and it was found on inquiry that in this instance the apparent decrease of albumen corresponded with a sudden rise in the daily excretion of urine from 16 to 130 ounces, due to the exhibition of ten-minim doses of tincture of digitalis three times a day. Dr. Murchison pointed out that, comparing the increase in the quantity of the urine with the decrease in the proportion of albumen, the actual quantity of the latter secreted in twenty-four hours remained about the same as before. He directed that the dose of digitalis should be reduced.—*Lancet*, Dec. 3, 1870.

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Diagnosis of a Case presenting Acute Pyrexia, with Eruption on the Face.—Two days before admission into Middlesex Hospital, this patient had experienced severe rigors, which were shortly followed by pain in the head, back, and left side; at the same time he became hot, and began to vomit. The pain and vomiting continued throughout the second day. On admission, about forty-eight hours after the onset of the symptoms, there was an eruption on the face; the skin was found to be dry, with a temperature of 104°; the pain remained present in the situations indicated, and had become increased in the left side, and the patient continued to vomit. The points in favour of variola were said to be the vomiting and high temperature so early in the disease, and the pain in the back; against it were the increasing pain in the left side, and the facts that the temperature remained high, although the eruption on the face was well marked, and that this eruption itself was found on examination to present the distinctive characters of acne. It appeared, therefore, that there must be some local inflammation in the chest, and attention was directed to the base of the left lung, the site of the pain. On the day of admission neither dulness on percussion nor crepitation had been detected in this situation; but the breathing had been found to be less vesicular than at the opposite base, and accompanied by bronchitic râles. At the present time (the following day) the temperature was 103.8°; there was an acute herpetic eruption on the lips; there were two inches of dulness at the left base posteriorly, and in the left infra-axillary region and in the lower half of the left back friction-sound and distant tubular breathing were heard. The patient had a cough, and brought up rusty sputa. These conditions indicated plainly enough that the case was one of pneumo-pleuritis, though the general dis-

turbance had been far in excess of the amount of local disease. There was a small quantity of albumen in the urine, and it remained to be proved whether the renal complication was a consequence of the chest inflammation, or whether the great constitutional disturbance, the chest inflammation, and the albuminuria, were not the consequences of the presence of a general poison in the blood. Dr. Murchison ordered a mustard and linseed poultice to the affected part of the chest, and ten minims of tincture of aconite three times a day, to be reduced to five as soon as an effect should be produced on the pulse.—*Lancet*, Dec. 3, 1870.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Exsection of the Head of the Humerus for "Chronic Rheumatic Arthritis."—Prof. George C. Blackman records in our esteemed contemporary the *American Practitioner* (Jan. 1871), the following case of this:—

P. H., æt. 50, was admitted into the surgical ward of the Cincinnati Hospital, March 31, 1870. Fifteen years ago he lost the index-finger, and all the terminal phalanges of the left hand, from the effects of frost. Two years subsequently he sustained a compound fracture of the right arm, necessitating amputation at the lower third. He had never contracted a venereal disease. Four months previous to admission the anterior portion of the thorax was thickly covered with an eczematous eruption, and a large tumour presented itself in the left mammary region, from which came a free purulent discharge.

On admission there was very limited use of the left arm; the head of the humerus could be thrown easily from the cavity by passive motion, giving a crackling sensation; a chain of enlarged lymphatic glands was traced down the axillary region. The tumour was the size of a blacksmith's fist. The spontaneous opening was enlarged, and a large amount of purulent matter evacuated. The eruption gradually yielded to the administration of liq. potass. arsenit., and the general condition of the patient was much improved by large doses of syrup of iodide of iron and manganese.

On the 24th day of May an incision was made from a point over the left acromion, extending downward three and one half inches; and when the capsular ligament was penetrated a yellow thin fluid escaped, and a fistulous tract connecting the cavity of the joint with the pectoral abscess was disclosed. Through this incision the dislocated head of the humerus was turned out, and two inches of porous, softened bone removed with the saw. A solution of five grains of carbolic acid and one ounce of water was injected down the fistula, and a compress adjusted. Quinia and whiskey, with a nourishing diet, were ordered. By the 14th of June the tumour had disappeared, and the discharge of the purulent matter from the lower opening was slight. Early in September the incision over the joint was completely closed, and he was transferred to the infirmary in excellent health.

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Deaths from Chloroform.—In the number of the *Cincinnati Lancet and Observer* for Jan. 1871, there are reported, by Dr. W. W. Dawson, Surgeon to Cincinnati Hospital, the notes of twelve hitherto unpublished cases of death from chloroform.

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Episcopal Hospital.—Drs. H. B. Hare and Herbert Norris have been elected physicians to this institution, vice Drs. H. C. Wood and E. A. Smith, resigned.

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Philadelphia Hospital.—Horatio C. Wood, Jr., M.D., has been elected to fill the post of physician in this institution, made vacant by the resignation of Dr. Edward Rhoads; and Geo. Pepper, M. D., visiting accoucheur, vice Dr. Schofield, resigned.

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Dispensary for Skin Diseases.—An incorporated Institution, bearing this name, has been organized in Philadelphia, for the purpose of giving gratuitous advice to those afflicted with cutaneous maladies. Dr. L. A. Duhring has been appointed physician to the dispensary, which is located at No. 216 south Eleventh street, and is open daily at 11 o'clock.

Obituary Record.—Died in Philadelphia, Jan. 1, 1871, of pneumonia, John Rhea Barton, M. D., aged 77. Dr. Barton graduated in Medicine at the University of Pennsylvania in 1818, and was subsequently in active practice for about twenty years, during which time he achieved a high reputation by his numerous and valuable contributions to surgical art and literature. Brought up under the tutelage of Dr. Physick, his operations were characterized by the extreme neatness and carefulness of that great master, with, perhaps, even greater boldness, brilliancy, and originality. His name is inseparably connected with certain operations, as that for the relief of anchylosis by the formation of an artificial joint, and also with a peculiar fracture of the lower end of the radius, known as Barton's fracture. He was for many years one of the Surgeons to the Pennsylvania Hospital, and contributed largely to the fame of that institution.

Dr. Barton retired from practice more than thirty years ago, after a career, short it is true, but one of rare brilliancy, and of lasting, not ephemeral, usefulness.

Among some of his more important contributions to surgical literature, may be mentioned the following: Treatment of Anchylosis of the Hip-joint by the Formation of an Artificial Joint (*North Am. Med. and Surg. Journ.*, vol. iii. April, 1827); A New Treatment in a Case of Anchylosis (*Am. Journ. of Med. Sci.*, Feb. 1838); Longitudinal Section of the Lower Jaw, for the Removal of a Tumour (*Am. Journ. of Med. Sci.*, Feb. 1831); Operation performed and recommended for the Cure of Imperforate Anus (*Med. Recorder*, vol. vii. 1824); On Certain Injuries of the Bones of Children (*Ibid.*, vol. iv. 1821); On a Peculiar Fracture of the End of the Radius (*Med. Examiner*, vol. i.); A New Treatment in a Case of Anchylosis of Knee (*Am. Journ. of Med. Sci.*, vol. xxi.) etc.

He was also the inventor of a lithotomy forceps (*Philad. Journ. of Med. and Phys. Sci.*, vol. viii. p. 147); of the fracture box (*Am. Journ. of Med. Sci.*, vol. xvi., 1833, p. 31); of the "bran dressing" for compound fractures, (*Ibid.*, April, 1842, p. 515); of a bandage for fracture of the lower jaw (*Am. Med. Rec.*, April, 1819, p. 153); etc.

——, in Philadelphia, Jan. 15. 1871, aged 29 years, Edward Rhoads, M. D., late Physician to the Philadelphia Hospital, and Clinical Lecturer on Physical Diagnosis in the University of Pennsylvania. Dr. Rhoads was distinguished for his great industry, the extent and accuracy of his knowledge, the soundness of his judgment, and his great modesty. His career had given promise of remarkable usefulness and success, and his loss is deeply deplored by a large circle of professional and personal friends.

——, in Richmond, Va., Dec. 27, 1870, Beverly R. Welford, M. D., late Professor of Materia Medica in the Virginia Medical College, and a gentleman highly esteemed for his honourable character as well as for his professional attainments.

FOREIGN INTELLIGENCE.

Treatment of Scarlet Fever.—In a recent article (*British Medical Journal*, Dec. 24, 1870), Dr. Renfrew says, in the treatment of scarlet-fever, agents should be given that will prevent the reabsorption of the poison, hinder its formation, moderate and assist physiological and chemical actions and changes.

The medicine which I have used for these purposes for nearly eight years is a mixture containing tincture of steel and chlorate of potass. In this mixture we have chlorine, muriatic acid, iron, and chlorate of potassa. The chlorine acts upon and destroys the poison in the stomach; and probably some of it is taken into the blood, producing the same effect there. The muriatic acid, Dr. Chambers says, "is such a large constituent of the body, that it might almost be called a food, instead of a medicine; and that it is a powerful arrester of decomposition of animal matters." He also says about the ammonia, "very difficult would it be for the eliminator to get this alkali out; but it is easy for the restorers to get acid in." By getting the acid in, we lessen the alkalinity of the blood, and neutralize one of the conditions favorable for the develop-

ment of the poison. The red disks of the blood are the carriers of oxygen; but, in their "black and melanosed condition," they are not in a condition for accomplishing this function The iron supplies that which is likely to improve the deteriorated disks, and we give that which we know rapidly increases their number. The chlorate of potassa supplies oxygen to the blood—which must be very deficient, from the condition of the red disks and the rapid disintegration that has been going on—to enable the physiological and chemical changes to take place, and oxidize the disintegrated substances that are floating in the blood.

The forms in which he gives the medicine are the following:—

1. For a child two years old: ℞ Tinct. ferri perchloridi ʒiss vel ʒij; potassæ chloratis ʒj; glycerinæ ʒiss vel syrupi simplicis ʒj; aquæ q. s. ad ʒiv. Two teaspoonfuls to be taken in water every hour or two hours.

2. For an adult; ℞ Tinct. ferri perchloridi ʒiv; potassæ chloratis ʒiij; glycerinæ vel syrupi simplicis ʒiss; aquæ q. s. ad ʒviij. One tablespoonful in water every hour or two hours.

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Etiology and Treatment of Diphtheria.—Prof. Steiner, of Prague, has published in the *Jahr. f. Kinderk.* of November 1st, 1870, a series of cases in which he was able to try different kinds of treatment, and watch the result. He thinks that the etiological question is not as yet solved, although very great authorities consider diphtheria to depend on blood-poisoning. Nor can the purely local cause, in the shape of germs, be satisfactorily proved. Further investigations are indispensable to decide between the two theories. Therapeutically, the professor considers that the means which answered best in his hands are lime-water locally, and, internally, quinia, chlorate of potassa, and wine; when laryngitis occurs, emetics; and if they act no more, tracheotomy. When paralysis follows the acute attack, tonics are to be recommended, but the author has found that in many cases the symptoms of paralysis disappeared without treatment.

Dr. Moritz Schlier has tried carbolic acid extensively in diphtheria, his reason for using it being the supposed existence of germs in this disease. The solution used was 1 in 16, and it was energetically applied to the false membrane by means of the finger wrapped in some linen. No internal remedy was employed; but those patients whose age allowed them to gargle, were made to wash out the mouth with the above-named solution every half hour. Out of 36 cases, 13 recovered, and these were all very severe; most of the patients, also, were out of danger in about four or five days. During convalescence, tonics and wine were liberally used.—*Lancet*, Jan. 7, 1871.

—

Calabar Bean in Constipation.—Dr. Victor Subbotin (*Arch. f. Klin. Med.*, vi. 2, 3, 1869) communicates cases in which he obtained remarkably good results from this remedy. He prescribed a solution of the extract in glycerine, one to thirty, the dose being four drops four times daily. A fecal tumour which resisted strong doses of a cathartic was quickly dispelled in this way. The cases in which the treatment is most suitable, are those due to atony of the muscular coat of the bowels, on which the Calabar extract acts powerfully, as is shown by experiments on animals.—*Med. Press and Circular*, Jan. 4, 1871.

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Sulphurous Acid in Typhoid Fever.—Dr. Wilkes, of Ashford, Kent, affirms (*Med. Press and Circular*, Dec. 14, 1870) that he has had very great success in the treatment of typhoid fever by means of small doses of sulphurous acid. He gives the acid with syrup of oranges in water, in doses of from two and a half to twenty minims every four hours, until the patient complains of tasting, as it were, lucifer matches. He alleges that this remedy arrests the further development of the fever-poison, and thus *exterminates* the fever. "Briefly it is an antidote." Of 173 cases of typhoid fever treated, only two died, and these two did not take the acid.

—

Bromide of Potassium in Ague.—Bromide of potassium was first introduced into

medical practice, as a remedy for enlargement of the spleen, by Dr. Williams. Dr. Moxon has lately been trying among the out-patients at Guy's Hospital, the bromide in cases of ague (*British Med. Journ.*, June 11, 1870). The results are such as to show that this drug possesses very remarkable power over ague, and a power that promises to be of important use in many of the more obstinate cases. In one case illustrative of its action, the patient had had tertian ague for two months before admission to the hospital, and had taken quinia without benefit; after admission he took eighty-four grains more without benefit. Twenty-grain doses of bromide, three times a day, were then given, and he was discharged cured in ten days. It is found always to check the ague, and often to cure it permanently, not always; but that is the case with any remedy.

—

A Remedy for Sea-sickness.—There have been many suggestions made as to the prevention of sea-sickness, none of which have, to say the least, been found in practice to be completely successful. The introduction into practice of hydrate of chloral, which produces with certainty sleep for a definite number of hours, has suggested a means of escaping the horrors of a short sea-passage at least, and possibly of mitigating the most prolonged horrors of sea-sickness. To go asleep at Dover, and to wake to find one's self at Calais, is a plan which, failing other expedients, has in it much promise. An ordinary dose of hydrate of chloral produces sleep usually in a quarter of an hour, and with almost unfailing certainty. Some cases just published by Dr. Doring of Vienna seem to show that the value of hydrate of chloral to obviate sea-sickness is very great. It produces quiet and prolonged sleep. In all the instances recorded, it seems to have been of great value even during prolonged sea-voyages, giving a good night's rest, arresting violent sickness when it had set in, and stopping the tendency to its recurrence.—*Brit. Med. Journ.*, Dec. 3, 1870.

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Treatment of Housemaid's Knee.—Mr. Thompson, of Westerham, gives (*Brit. Med. Journ.*) a series of cases showing the beneficial results of the application of the plaster of ammoniacum and mercury to cases of inflamed bursa patella, which he thinks is not so generally known and accepted as it ought to be. The following is one of the cases reported: On July 18, 1868, a housemaid awoke in the night with acute pain at the knee. I found great pain, heat, and tenderness over the patella. The bursa was much swollen. She was feverish and ill, and was ordered to remain in bed, and keep the knee covered with spirit lotion. On the 23d the acute symptoms had subsided. The bursa was very distended with fluid. The plaster was applied. On the 30th the swelling was entirely absorbed, and she was at work again. — *Practitioner*, Nov. 1870.

—

Neuralgia of Jaw following Tooth-Extraction; Treatment by Prof. Gross's Method. —In the number of the *American Journal of the Medical Sciences* for July, 1870, is a description by Prof. Gross, of a form of neuralgia of the jaw-bones following tooth-extraction, and depending, as he thinks, on compression of the alveolar nerves by the osseous material deposited during the reparative process. The following is an example of the affection.

Solomon K., aged 18, had for some weeks been attending as an out-patient at the Leeds Infirmary, on account of excruciating pain in the lower jaw. Six months ago, the left lower anterior bicuspid tooth was removed in a state of decay. In from a week to ten days afterwards, he began to suffer intense pain in the part, and occasionally a little blood oozed from the gum. He sought relief from many sources, but in vain; and during his attendance as an out-patient at the infirmary, the usual anti-neuralgic remedies had been prescribed to no purpose. The affected gum was hard, and adherent to the bone; and pressure upon it aggravated the pain, which, though chiefly felt where the tooth had been, radiated to a considerable distance around. After having seen Dr. Gross's statement, Mr. Jessup admitted the young man; and, on October 20th, he cut down upon and removed with bone-forceps and

gouge a portion of the alveolar border. The relief was complete, and continued up to October 29th, on which day he was discharged. He has not since been seen. —*British Med. Journal*, Jan. 7, 1871.

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Fatal Results of Caries of the Temporal Bone.—Dr. E. H. Bennet showed to the Pathological Society of Dublin, two specimens illustrative of the fatal results of caries of the temporal bone. Both patients were women, and had, previously to their fatal illnesses, enjoyed good health with the exception of occasional slight otorrhœa. The first patient, aged forty years, became suddenly excited, violent headache set in, and in two or three days she became comatose, and never rallied. After death, appearances similar to those in fatal cases of cerebro-spinal arachnitis were noticed. An extensive decomposition of lymph had taken place in the pia mater beneath the arachnoid membrane. The lymph lay thickest close to the origin of the seventh nerve of the affected side; and around its insertion into the medulla oblongata, a perceptible induration existed. The lateral sinus was healthy, but the entire petrous portion of the temporal bone was softened and red. The portio mollis was adherent in the internal meatus, and the tympanum was destroyed. These latter lesions were evidently of an old date. The inflammatory action in the fatal attack had probably originated in the seat of the primary disease, and spread thence inwards along the course of the portio mollis. The second patient, aged thirty-five, had been attacked with severe pain in the head. Sudden symptoms of general pyrexia followed, and shortly afterwards complete paralysis of the portio dura on the affected side. In this instance, death was clearly due to pyæmia, pleuritis and general pulmonic congestion having set in before death. Here, signs of meningitis were wanting; for, though the brain was somewhat congested, no purulent deposits had occurred. An encysted abscess was found in the temporal bone, and the petrosal and cavernous sinuses were full of purulent matter. Deposits of pus were discovered in the lungs. A remarkable symptom which had been present during life, was explained by the condition of the cavernous sinuses. This was the extreme distension of both conjunctivæ with serous fluid, the result of passive congestion in the ophthalmic veins. The nerve-trunk of the portio dura had apparently been destroyed shortly before death.—*Brit. Med. Journ.*, Dec. 24, 1870.

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Skin-Grafting.—Dr. David Page, of Edinburgh, has made some investigations (*British Medical Journal*, Dec. 17, 1870) which throw a very important and interesting light on this subject. All observers agree in describing the disappearance of the characters of true skin in the piece laid on the wound, and the resulting appearance of a small pellicle, which ultimately becomes a centre of cicatrization. Mr. Nelson Dobson, in the paper which he read at the Bath and Bristol Branch of the British Medical Association, described the excellent results from splitting fine shavings of skin into small pieces; and all authorities have agreed from the first that the skin taken should be completely free from subjacent areolar or adipose tissue. Dr. Page goes still further. Microscopic examinations into the physiological characters of the process have convinced him that "the so-called skin-grafting consists in truth not of a transplantation of true skin, but of epithelium." The pellicle, which retained its vitality, and proved of initial value in inducing cicatrization, was found to consist of young epithelial cells. Further, the cicatrix thus induced, and that formed by the ordinary normal process elsewhere, were undistinguishable one from the other, and, under the microscope, proved to be of the same fibro-cellular character.

Dr. David Fiddes, of the Royal Infirmary, Aberdeen, has clinically arrived at a conclusion which affords a remarkable support of Dr. Page's observations and deductions, if confirmed by further observations. He says that it is quite unnecessary to put the patient to the pain of cutting a piece of healthy skin from the body for the purpose of transplanting it on the sore. "All that is necessary to be done," he says, "is to take a long bistoury,

or razor, and shave or scrape off the epidermic scales from the convex parts of the extremities, such as the outer and convex aspects of the forearms and thighs, and place them on the healthy granulations. This can best be done by brushing the scales off the bistoury with a camel-hair pencil. After securing them *in situ* for three or four days by means of common adhesive plaster, the granulations on which the epidermic scales were placed assume a glazed bluish appearance, which gradually grows into skin, and meets the nearest edge of the healing ulcer, which edge shoots out and meets the newly-formed skin on the granulations. The result is continuity of healthy skin." This last, it will be observed, is a very important statement. Dr. Page's observations lead him to the opposite conclusion, that there is no nearer approach to the condition of true skin than in cases of ordinary cicatrization, but only a more rapid formation, and from a greater number of centres, of a tissue of very low vitality, deficient in many of the functions of the true skin, and easily destroyed by causes that would not affect the latter. The sphere of usefulness of the operation will be largely affected, according as the one or other view proves to be correct. No doubt clinical observations will multiply; and we direct attention to these points, as the best method of furthering the discovery of the place in surgery of this new and suggestive practice.—*British Medical Journal*, Dec. 24, 1870.

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Cause of the Occurrence of Labour at the Close of the Ninth Month of Utero-gestation.—Prof. Alex. R. Simpson, in his introductory lecture (*Edinburgh Med. Journal*, Dec. 1870), gives the following explanation of this: "Since the true nature of the decidual membrane came to be fairly understood, it was natural to seek in the changes which it undergoes for an explanation of the cause of the occurrence of labour at the close of the ninth month of utero-gestation. The search has not been fruitless. For it has been found that in the natural course of development, the decidual membrane at this period has undergone a degree of fatty degeneration which has brought it to the last stage of its existence, when it would either require to be melted down and absorbed, or be thrown off as a foreign substance. The same change occurs in it at an earlier date if through some disease an end be put to the life of the fœtus, and in such a case expulsion of the dead child does not take place until time has been given for the degeneration to occur in the decidua, which leads to its being loosened from the uterine parietes and reduced to the condition of a foreign body. The observation of this phenomenon has led by a beautiful induction to the employment of the simplest, safest, and surest means of bringing on labour, by imitating the process of nature and producing an artificial separation of the membranes from the interior of the uterus in those cases where, to save the life of the child and to lesson the mother's risk, it is found needful to induce the labour prematurely.

—

Chloralum.—Dr. Stevenson read (December 17, 1870) before the Association of Medical Officers of Health, his report on chloralum as an antiseptic and disinfectant. The substance, aluminic chloride, was not new to chemists. It seemed to have no action on sulphuretted hydrogen. It would deodorize some compounds perhaps, because it fixed ammonias and organic ammonias. In its antiseptic properties, it seemed to be like many other mineral salts. It stopped putrefactive change to a great extent, but seemed inferior to carbolic acid. It was difficult to determine whether it had disinfectant powers; probably it had. Dr. Stevenson thought that in any case its expensiveness, as compared with carbolic acid and other disinfectants now in use, would weigh against it. It might be of advantage in the case of dead bodies, where the preservation of color was of importance. —Mr. John Gamgee had been assured by Dr. Angus Smith and others, that this was almost an untouched subject. He claimed for chloralum a superiority over carbolic acid, on account of its inoffensiveness and harmlessness; and because the strength could be moderated at pleasure. It was

applicable to ten times as many purposes as carbolic acid, and could eventually be manufactured at one-third the price.—*British Medical Journal*, Dec. 24, 1870.

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Comparative Energy of Antiseptics.—Dr. F. Crace Calvert has performed two series of experiments in order to ascertain the comparative powers of various substances ordinarily used as antiseptics. The first consisted in placing in bottles (not corked) solutions of albumen and flour paste. To these he added various proportions of some of the substances patronized at the present time as antiseptics.

The results of these experiments clearly show that the only true antiseptics are carbolic and cresylic acids; and these results coincide with those obtained by Mr. William Crookes, F.R.S., Dr. Angus Smith, F.R.S., and Dr. Sansom. These two acids continued their action till the albumen solution and paste dried up. The second series had the object of ascertaining which of the undermentioned substances would possess the most active power in destroying such germs, and thus preserving the animal substance from decay. At the bottom of wide-mouthed pint bottles, Dr. Calvert placed a known quantity of each of the antiseptics, and suspended over them by a thread a piece of sound meat; and, by daily examination, it was easily ascertained when the meat became tainted or putrid. The following table gives the results obtained:—

Antiseptics used.	Became tainted.	Putrid.
Permanganate of potash	2 days.	4 days.
Chloralum	2 "	10 "
McDougall's disinfecting powder	12 "	19 "
Chloride of lime.....	14 "	21 "
Tar oil.....	16 "	25 "
Chloride of zinc.....	19 "	—
Carbolic disinfecting powder	Did not become tainted, but dried up and became quite hard.	
Carbolic acid.....		
Cresylic acid.....		

British Medical Journal, Dec. 24, 1870.

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Hydrate of Bromal.—The hydrate of bromal, or bromal-hydrate, is the corresponding compound to chloral hydrate, the chlorine being replaced by bromine. Its composition is $C_2\,HBr_3\,O,\,2H_2O$, it being formed by the direct action of bromine upon alcohol.

From experiments made under the supervision of Liebreich himself in the Berlin Pathological Institution, and published some time since in the *Press*, it would seem that this compound when administered to animals, undergoes a similar change to the chlorine compound. But this change goes on much slower; at the end of an hour and a half there is found in the blood, in addition to bromoform, still some undecomposed bromal. It is also evacuated in the urine as bromides.

The symptoms produced upon animals were—first, a stage of restlessness, followed by imperfect sleep and anæsthesia, and finally dyspnœa and death with and without convulsions.

The preliminary stage of restlessness which has no equivalent in the administration of chloral is ascribed to the action and conversion of the bromal into aldehyde. It being oxidized in the usual manner by the arterial blood the decomposition proceeds much more slowly than it would in the case with chloral. The author and others, however, had observed a stage of restlessness after hypnotic doses of chloral. In the case mentioned by Liebreich, a patient was suffering from gout, and it was no doubt due to the acid state of the blood preventing the usual decomposition into chloroform. When alkalies were administered to the patient the same dose of chloral hydrate produced sleep. It would be most desirable to try some experiments upon these compounds, particularly as regards their exhibition in conjunction with ammonio-citrates of the alkaline bases; it is probable that the uncertainty exhibited by chloral hydrate would vanish by such a method.—*Med. Press and Circular*, Jan. 4, 1871.

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The Phenomena of Death by Drowning and Cold.—The phenomena of death by drowning and cold formed the subject of Dr. Richardson's experimental and practical lecture on Tuesday. He showed, amongst other experiments, that fish which would be presumed to be dead from what he called "glacial death" were easily recoverable. His view as to the sudden-

ness of the collapse of the body in water at freezing-point is, that the exhaustion follows on peripheral nervous shock, due to the cold, and quick succeeding exhaustion of the nervous centres. Thus the temperature of the brain was reduced to 56° F., in an animal drowned in freezing water, while the temperature of the chest and abdomen was at 79° F. Death from drowning under ice is, Dr. Richardson states, one of the most rapid of deaths, and is completed, he believes, with so quick an extinction of consciousness as to be actually painless. The heart retains its power of action, the blood remains fluid, and the muscles keep up their irritability for a long time after apparent dissolution; and so favourable are all the conditions for the renewal of living action, even for two hours, that a considerable advance in the practice of resuscitation must follow upon further careful and laborious experimental research.—*Lancet*, Jan. 7, 1871.

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Spontaneous Generation.—This subject is at present attracting great attention, and many of the most competent investigators are at work endeavouring to elucidate it. Prof. Huxley, in his address, brought it to the attention of the British Association for the Advancement of Science at its late meeting, presenting an able exposition of his opinion which brought out the views of others, giving rise to a very animated discussion. In that address, as remarked in the *Lancet* (Dec. 31, 1870), Prof. Huxley "stands forward as an opponent of the theory of spontaneous generation, except in so far that, if it were 'given him to look beyond the abyss of geologically recorded time to the still more remote period when the earth was passing through physical and chemical conditions which it can no more see again than a man can recall his infancy, he should expect to be a witness of the evolution of living protoplasm from not living matter'; otherwise he holds that inorganic cannot form organic compounds except under the influence of pre-existing protoplasm. Dr. Bastian, on the other hand, endeavours by numerous and carefully conducted experiments to show that, under conditions that preclude the idea of the pre-existence of ova or living particles of any kind, organisms of low type—such as bacteria, vibrios, and various simple fungi—may develop when their chemical elements are brought into relation under otherwise favourable circumstances of light, heat, and moisture. Prof. Tyndall's researches here come in, showing that, under all ordinary conditions, the atmosphere is charged with a fine dust clearly of an organic nature, since it is destroyed by a red heat, and which, as we do not yet know its precise relations to temperature, may possibly contain the germs of such organisms as have not been destroyed by the temperatures to which Dr. Bastian's infusions were subjected. The question will be settled when some inquirer obtains a living and growing organism from chemically pure oxygen, hydrogen, nitrogen, and carbon in the presence of water—a consummation from which we appear to be sufficiently distant as yet."

—

Medical Science in Paris during the Siege.—Dr. J. A. Fort, writing from Paris on Nov. 24th to Prof. Pacini of Florence, says that the Surgical Society attempted to resume its weekly meetings on November 7th. Seven members only were present. M. Boinet spoke of some cases of tetanus which he had observed among the wounded in the Palace de l'Industrie; he attributed the disease to cold—the wards being badly warmed. M. Giraldès had also seen some cases of tetanus in the Val-de Grâce Hospital. Both these surgeons spoke in praise of chloral, the use of which had been followed by recovery in two-thirds of the cases. The amount given varied from eight to ten *grammes* in twenty-four hours; it was dissolved in simple syrup, and given in doses of a spoonful. The Academies of Medicine and of Science were also meeting, and were occupied in discussing the existing state of affairs. The Session of the School of Medicine had commenced, and the professors had begun their lectures. Dr. Fort had commenced giving a course of surgical anatomy.—*British Medical Journal*, Dec. 31, 1870.

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Not only is it the best work on venereal diseases in our language, with which we are acquainted, but one of the pleasantest to read.—*Am. Journ. Med. Sciences*, Jan. 1871.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Diagnosis of Typhoid Fever.—Dr. CHAS. MURCHISON, in the course of a clinical lecture "On some of the Varieties of Enteric Fever," remarks as follows:—

It may be asked, however—How are we to diagnose enteric fever if its recognized pathognomonic symptoms be wanting? In reply, it must be admitted that in many cases a diagnosis can only be arrived at by a process of exclusion; but, practically, I believe that the rule which I am about to lay down will in most instances be found to hold good. A fever which *in this country* (aguish districts excepted) persists beyond seven days, and is unattended by any cutaneous eruption, or by signs of local disease in the head, chest, or elsewhere, is typhoid or enteric fever, even though there be no symptoms directly referable to the intestinal lesion. In all such cases you ought to suspect the existence of intestinal disease—I do not say ulceration, but disease—of the agminated and solitary glands of the ileum. The enlargement of these glands, which goes on increasing till the tenth day, may then resolve, instead of proceeding to ulceration; but, unfortunately, it is impossible from the symptoms to decide which of these courses the intestinal lesion is pursuing, and ulceration is certainly the more common result. But the question naturally arises, and in fact is constantly put, as to what grounds there are for saying that in the cases of fever I have now described there is any intestinal lesion at all. Patients with these mild attacks usually recover; no opportunity is afforded of see-

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ing the intestinal lesion; and if it gives rise to no symptoms, how do we know that it exists? The grounds for the opinion now expressed are these:—

1. Mild cases of continued fever answering to the above description are constantly found occurring in the same house, and at the same time, as well-marked examples of typhoid or enteric fever. The two forms appear thus to have a community of origin.

2. Many, though certainly not all, of the mild cases I have described present successive crops of lenticular rose spots, identical with those met with in typical enteric fever.

3. Lastly—and it is this important practical fact which chiefly justifies these remarks—although the majority of these mild cases recover, it now and then happens that after several weeks such a case terminates suddenly in fatal hemorrhage or perforation. Over and over again I have met with patients with a mild attack of fever, which has caused little anxiety, and in which the existence of intestinal disease has perhaps not been dreamed of until the occurrence of profuse intestinal hemorrhage or acute peritonitis has revealed the real nature of the case. In several instances of this sort I have known the bowels to be obstinately constipated up to, or almost up to, the outburst of the fatal symptoms, which have occasionally appeared to be determined by the incautious use of solid food, by the injudicious administration of a purgative, and still more by the patient being permitted to get up and move about at a stage of the disease when a thin film of peritoneum was all that separated the intestinal contents from the abdominal cavity. Indeed, with regard to perforation in enteric fever, it has been a common observation, that in a large proportion of cases where it occurs the intestinal lesion has been latent, and the case altogether mild, prior to the occurrence of peritonitis; while anatomical research has shown that in many cases the perforation is due to a laceration of the denuded peritoneum.

I could give you the details of many cases as evidence of the truth of what I have now said; but within the last few days you have had an opportunity of witnessing such a case for yourselves.

Case 6. *Enteric Fever running a mild course up to the occurrence of Fatal Peritonitis.*—Thomas K——, aged seventeen, a painter, was admitted under my care on October 15, 1870, and died within twenty-four hours. When first admitted he had all the symptoms of acute peritonitis—viz.: features pinched, and body covered with a cold clammy sweat. Pulse one hundred and forty; respiration fifty-six, and thoracic; abdomen distended, tender, and motionless, and legs drawn up; frequent vomiting, and scanty urine.

The history obtained from his mother was this. The boy had followed his work till October 7th, although for ten days before he had complained of being "out of sorts." He had no diarrhœa, and was not thought to be dangerously ill; and, in fact, had kept going about until the afternoon of the day preceding admission, when he was obliged to go to bed on account of a sudden seizure with acute pain in the abdomen, followed by the symptoms for which he was brought to the hospital.

When the body was examined after death, numerous "typhoid ulcers" were found in the ileum of a stage answering to about the eighteenth or twentieth day of the disease. One Peyer's patch, twelve inches above the valve, had sloughed out bodily, leaving an opening through all the coats of the gut, through which the finger could be passed. The contents of the bowel were found in the peritoneum, and there were the signs of extensive recent peritouitis.

The practical lessons which I wish you to draw from the remarks I have now made, are these:—

1. Even in the mildest cases of enteric fever, where there are no enteric symptoms, it is important to recognize the existence of the intestinal lesion, because at any time this may become suddenly a source of danger.

2. In all cases of enteric fever, during the third and fourth weeks, you must never omit to enjoin upon the patient's friends the necessity of maintaining absolute rest of body, and of abstaining from

solid food and the use of purgatives.—*Lancet*, Dec. 10, 1870.

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Clinical Lecture on Treatment of Local Syphilitic Sore.—Mr. Skey, in a clinical lecture on syphilis (*Lancet*, Nov. 5, 1870), recommends that if the local sore can be subjected to treatment within a term of three days, free cauterization with nitric acid, or other escharotic, will generally convert it into an innocuous ulcer. After three or four days the treatment throughout should be purely negative. No specific agents are useful. Simple dressing of spermaceti is as good as any other. In the latter stage, or that which immediately precedes cicatrization, the nitrous oxide of mercury ointment will accelerate the healing process. No condition of this sore in any of its well-marked stages can warrant the employment of mercury. If the soft sore in its progress show a tendency to deposition beneath it, and it assume the condition of induration, although the indurated base exhibits less dimensions than the primary hard sore, yet the question of mercury immediately occurs to the mind of the surgeon.

And on the subject of mercury I must occupy your attention for a few minutes. The influence that mercury exercises on the deposit of hard sores has been long known to the medical world. By Mr. Hunter it was resorted to indiscriminately in all forms of venereal sores, and it is perhaps not surprising that his successors (excepting always the school of Abernethy) should have resorted to mercury as the great and universal antidote to venereal sores, whether hard or soft, whether local or constitutional. But since venereal diseases have become the subject of more critical observation, our lines of demarcation are more closely defined; and while we are compelled to resort to mercury in some forms of the disease, we as rigidly eschew it in others.

The action of mercury tends to increase the secretions of the body, and at the same time to promote absorption of morbid deposits. It cannot be said to exercise any direct influence on the *poison* of syphilis, but only on the effects or consequences of the poison. It is not to be considered as exercising the power of a specific, because it cannot destroy the poison. It has the power to lessen and to obtain absorption of the hard deposit, but the poison remains behind to develop itself hereafter. If it were a specific, if it possessed the power to directly neutralize the poison, a man under salivation would be unsusceptible to the influence of the disease after intercourse, which he assuredly is not. It is not very uncommon for the eruptive stage to appear during the treatment by mercury for the primary sore. I believe a course of mercury, if exhibited with due care and moderation, is not necessarily injurious to the health; but it is painful to read the frightful and often fatal extremes to which it was carried in the early part of this century. As almost a matter of course, surgeons resort to mercury in every variety of hard sore, because it would appear to be a great object to attain the absorption of the thickened or indurated mass, and to heal the ulcer upon it. But is this object so essential as it appears? Look to the evidence on this head given by many eminent members of our profession before the Admiralty Committee.[1] You will learn therefrom that great doubts cling to the minds of some of these eminent men whether the treatment of primary sores by mercury tends either to prolong the interval before the secondary or constitutional symptoms develop themselves, or to lessen their severity when they do appear. In whatever form you administer mercury, watch carefully its effects on the local disease and on the constitution. As the hardness subsides, reduce the dose in a relation to the influence it appears to exercise. Avoid salivation in every stage, and maintain your patient's strength throughout. In the constitutional or eruptive stage, when it assumes the dry forms of psoriasis or of lepra, mercury is less injurious to the health in protracted cases; but employ it sparingly in all moist eruptions, vesicular, pustular, or impetiginoid. A great and valuable adjunct is ever found in iodine, and the iodide of potassium, in doses of from

[1] Report of Committee. *Vide* evidence of Langston Parker, Jonathan Hutchinson, S. A. Lane, and others.

five to fifteen grains, will often supersede the employment of mercury entirely. It may be combined with full doses of the tincture of bark.

HOSPITAL NOTES AND GLEANINGS.

Abdominal Disease.—Three interesting cases of abdominal disease have recently been under Dr. ALLBUTT's care in the Leeds General Infirmary, all occurring in young boys, and all discharged cured.

The first case was one of impaction of feces in the transverse colon, of six months' standing. Six months ago the boy was "seized with a pain in the body" when going to his work; he then discovered a lump in his body, which had remained ever since. His bowels, which were costive, had latterly been relaxed. Some symptoms of obstruction had also appeared, but not to any severe degree. On examining the body, a tumour was found exactly occupying the site of the transverse colon; it was irregular and doughy in feel, and dull on percussion. The general condition seemed to negative malignant disease, and the symptoms of obstruction were not complete enough for intussusception, nor was there blood in the stools. Dr. Allbutt pointed out how often diarrhœa was a sign of constipation, and depended frequently on irritation of the gut by retained fecal masses. The boy was treated by a succession of large injections of warm oil and gruel, which brought away black lumps of feces, and diminished the tumour piecemeal, as was evident on physical examination.

The second boy presented a more remarkable subsidence of a tumour. He was twelve years old, and came from Ripon; he complained of a heavy, painful lump in the right hypochondrium. This he had noticed for four years. He lived near a river, in a rather damp place, but said he had not had ague, nor did he know any one who had; nevertheless, the tumour was distinctly a very large spleen. A young woman had recently been under Dr. Allbutt's care for what he called "acute splenitis"—that is, the spleen became hot, tender, and enlarged, and there were febrile symptoms at the outset. She was much benefited by bromide of potassium, after long ineffectual treatment by quinia and other drugs. This boy's case seemed like that of the young woman, and bromide of potassium was ordered. For a week there was no improvement, but Dr. Allbutt's clerk made out during that time that the boy had suffered from "queer shakings" in a morning about the time the lump came and subsequently, and he had been cured of the shakings at Ripon Dispensary. Ten grains of quinia were therefore ordered at once, with a mixture containing two grains three times a day. On the next day but one, Dr. Allbutt went to the bedside and requested a student to diagnose the case (which was unknown to him). He seemed curiously at a loss, and others were called to the bedside with equal unsuccess. It became then evident that the spleen, which had been as large as a child's head two days before, had now wholly disappeared. This was a more rapid change than in the case recorded by Dr. Ogle, in this Journal for December 10, 1870. Twice, while in the house, this boy had "intermittent hæmaturia," which has been noticed in connection with ague. But under the microscope, broken-up renal epithelium was found, and many blood corpuscles. There were no salts, except a few crystals of triple phosphate.

The third case was one called by Dr. Allbutt "spurious peritonitis." As certain other cases are called spurious hydrocephalus, so these not uncommon cases imitate tubercular peritonitis so closely that an immediate diagnosis is scarcely possible.

In the present case, a boy was brought to the hospital, aged about twelve, who had been losing flesh some months. His skin was harsh, his flesh wasted, his cheeks fallen, and his eyes rather sunken. He had suffered also, and was still suffering, from wandering severe abdominal pains, and from constipation alternating with diarrhœa. The appetite was capricious, and the tongue red. The pulse was about one hundred, and weak. On examination, there was no definite disorder in the chest, but the abdomen was tumid and doughy to the touch; it was ten-

der, also, on percussion, and there were several tracts of indefinite dulness. Dr. Allbutt said that careful watching of the temperature for several days would generally decide the diagnosis, as in tubercle a higher evening temperature was to be expected. In spurious peritonitis the temperature might also occasionally reach 38° (C.), but not commonly or regularly. In the present case, the thermometer pronounced against tubercle and in favour of spurious peritonitis, which Dr. Allbutt attributes to disordered secretions, with the irregular bowels and tumid abdomen as a consequence, while the wasting is due to deficient assimilation. The indications for treatment are—to put the bowels in thorough order, to improve the secretions by alkalies, mild bitters, and podophyllin, and to put the patient upon bland and nourishing diet. When this treatment has set matters straight, a short course of cod-liver oil and mineral acid with gentian is generally sufficient to restore the health. At the same time he would remark that these cases, if neglected, might end in mischief of a more serious kind. The present patient was discharged in a month, quite cured, and looking fresh and well. Spurious peritonitis is more common among the ill-fed and neglected children of the poor, but it is seen also in the families of the richer classes.—*Med. Times and Gaz.*, Jan. 14, 1871.

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Treatment of Acute Tonsillitis with Belladonna.—Although many of the standard works on Medicine and Therapeutics omit to make any mention of the value of full doses of belladonna as a remedy in severe simple tonsillitis, its employment in this affection is not by any means novel. The following is a case in which its use was followed by a speedy recovery:—

A. C——, aged eighteen, had been ill for three or four days with severe left tonsillitis. On admission into St. Mary's Hospital, under the care of Dr. Handfield Jones, the left tonsil and the adjacent arch were found to be much swollen, and very red. The inflamed parts had been scarified with some relief, but the formation of abscess seemed to be imminent. The pulse was 100, rather weak; the temperature 100.4°. Five grains of calomel and an aperient draught were administered shortly after admission. When Dr. Jones saw the patient, he ordered twenty drops of the officinal tincture of belladonna to be taken in half an ounce of water every two hours. On the second day after admission the voice was much improved, and the patient had less difficulty in swallowing. On the fourth day the patient had slept soundly during the whole of the previous night; the pulse was natural, the swelling had much subsided, and she was free from all distress. On the eleventh day, the tonsil appeared to the eye to be quite natural, but when felt from the neck it still seemed to be somewhat enlarged. With the exception of four and twenty hours, during which the doses were given every four hours, the belladonna was taken every two hours until the fourth day; the frequency of the dose was then reduced to every four hours until the sixth day, when the treatment was discontinued. It will be seen that while the dose was repeated every two hours, belladonna was being taken at a rate of about ten grains of the extract in every twenty-four hours, though some deduction must be made for doses omitted at night, especially towards the close of the treatment. Nevertheless, neither in this case, nor in numerous others in which large doses of the drug have been prescribed by Dr. Jones for the same affection, has any toxic effect been observed to follow.

Dr. Jones considers that this medication is more appropriate where the tonsils are acutely inflamed than in those cases where there is general inflammation of the fauces, without special affection of the tonsils. In the latter case he thinks that either iodide of potassium or the solution of sesquichloride of iron, according to the quality and stage of the inflammation, is preferable; and though he often combines with the belladonna a little quinia, or sulphate of magnesia, or an emetic, according to the indications of the case, and sometimes the use of steam, or a blister applied externally to the neck, he feels justified in maintaining that the success which he has attained in the treatment of

these cases is not to be attributed so much to these auxiliary measures as to the belladonna. He always gives directions that the administration of the remedy shall be slackened as soon as the throat symptoms are materially relieved, or on the production of any toxic effect.

Dr. Jones does not pretend to decide whether the remedy operates by producing constriction of the arteries, or by a direct sedative effect on the elements of the affected tissues; but he proposes that, if further observation should confirm its value in acute tonsillitis, the patient should be saved the regularly recurring pain of swallowing doses of medicine, by reducing the preparation of the drug to the smallest possible bulk, or by injecting it subcutaneously in the form of atropia.—*Lancet*, Jan. 7, 1871.

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Diabetes Mellitus.—Dr. Ogle showed us four cases of this disease in one ward of St. George's Hospital, two being under his own care, and two under that of his colleagues. Of his own cases, one was dying with very severe lung symptoms. In the other case, the gums have all the appearance as if salivation had been induced by mercury. Dr. Ogle has understood from Mr. Haward, of Halesworth, under whom the patient had been, that this symptom of salivation had come on with the disease, and remained throughout, no mercury having been given. In one of his diabetic patients, Dr. Ogle showed us the uvula diverted to one side, and decided inequality in the anterior arches of the palate. In another diabetic case, he found the same appearances, only the deflection was to the opposite side. He noticed the fact of this deflection of the uvula being observed in two out of the four diabetic patients, alluding to the observations by Dr. Saunders, of Edinburgh, upon vertical hemiplegia of the palate in facial paralysis and in diabetes. He looked upon the fact of two out of four cases of diabetes, casually associated, presenting divergence of the uvula and inequality in the two palatal arches, as something more than accidental. In the fatal case of diabetes, Dr. Ogle has had the medulla oblongata and other parts of the brain reserved for microscopical examination.—*Medical Times and Gazette*, Feb. 4, 1871.

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Notes of Cases in Addenbrooke's Hospital, Cambridge.—The following cases have been under the charge of Dr. Bradbury, at his hospital:—

Eruption of Purpura under the Use of Iodide of Potassium.—During a recent visit to this hospital, we noticed, under the care of Dr. Bradbury, the case of a brewer's labourer (fifty-eight years of age, who had lived well for the last two years) in whom iodide of potassium, administered for rheumatic pains, twice produced an eruption of purpura on the thighs, legs, and arms. Dr. Bradbury said he felt convinced that the purpuric spots were due to the iodide of potassium, for when he ceased to administer the drug for a fortnight, the purpura disappeared. On the iodide of potassium being readministered, the spots reappeared, again to disappear on the drug being suspended. Dr. Bradbury informed us that the same effect of the drug had been noticed by Ricord and Virchow. The former had a syphilitic patient, who, whenever he was treated with the salt, suffered from purpura hemorrhagica. Virchow's case was one of cancer, the subject of which had purpura hemorrhagica whenever the drug was administered. Dr. Bradbury's patient had also had several slight attacks of epistaxis.

Incontinence of Urine treated by Hydrate of Chloral.—Amongst Dr. Bradbury's outpatients is a girl who had been troubled with incontinence of urine for nine years, wetting her bed, according to her own and her mother's account, every night. She was ordered fifteen grains of chloral hydrate every night, and since she took the first dose of medicine there has been no return of the complaint.

Santonine in Helminthiasis.—We also saw a girl suffering from helminthiasis (ascaris lumbricoides) who, her mother said, had passed *fourteen* worms since her last visit. Dr. Bradbury had, from the patient's symptoms, suspected worms, and had prescribed santonine, with the above result. He looks upon this drug as a spe-

cific for these worms, having never known the remedy to fail when properly administered.—*Brit. Med. Journal*, Feb. 4, 1871.

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Extension of the Leg and Stiffness of the Knee-Joint, the consequence of long-continued Inflammation of the Knee-Joint; Forcible Flexion; Recovery.—So complete a result, as regards the restoration of the function of the joint, as was observed in the following case, in spite of so much change in the motor apparatus, is quite unique.

Mary P——, aged twenty-three, was admitted into St. Mary's Hospital three years and eight months ago. All trace of acute disease had by that time passed away. The leg was straight and rigid. The ligamentum patellæ was so much contracted that the lower edge of the patella was drawn nearly to the tubercle of the tibia. That this was the chief source of the stiffness of the joint there was little doubt, but it was also certain that there were other changes about and without the joint which contributed to its rigidity. The muscles of the leg and of the thigh were much wasted from disuse. The patient walked with crutches, but very imperfectly. As there was no bony anchylosis, Mr. Hayes Walton thought the case to be a proper one for forcible flexion, by which adventitious adhesions about the joint might be broken through, and the extensor muscles stretched or more or less torn, and the joint made available. He thought, too, that if the joint were used the wasted muscles would regain much of their bulk and the limb its power. The patient was placed under chloroform, and with the exercise of a great deal of force, the leg was flexed on the thigh to the full extent. The operation was followed by constitutional irritation and local inflammation. The limb was kept in a straight splint for two months; an iron apparatus was then applied, and the patient began to move about the ward on crutches; at the same time, slight flexion was made daily, and gradually increased. She left the hospital at the end of five months. She was then unable to stand without the iron apparatus, but could walk without crutches. She could flex the leg to nearly the full extent when she was sitting or lying down. On leaving the wards she became an out-patient.

Eight months after her discharge from the wards the patient left off the apparatus and began to walk with a stick, bending the knee moderately well. A few days ago she was brought to the hospital by Mr. Walton, in order to show her present state. She has complete use of her joint, and can flex and extend the leg perfectly. She goes up and down stairs with ease and without halting. The muscles of the leg and thigh have nearly recovered their volume. The patella is still in its abnormal position; and when the leg is semi-flexed, the condyles of the femur, the trochlear surface between them, and the attenuated tendon of the conjoined muscles, can be distinctly felt.—*Lancet*, Jan. 28, 1871.

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Wound of an Artery in Opening an Abscess; supposed to be Malignant Disease.—Dr. Thomas Green, Consulting Surgeon to the Bristol Royal Infirmary, records (*Brit. Med. Journal*, Dec. 17, 1870) the following interesting case of this. A lad was brought into the Bristol Infirmary. On admission, one side of his face was much swollen and covered with layers of lint, strapping, and bandage, apparently to stop bleeding. They were all saturated with blood, and a weeping of blood was going on under these coverings. The history was, that the swelling was thought to be an abscess, and was punctured by a surgeon; no pus, but blood followed the puncture. The case was then thought to be one of malignant disease, and was sent to the infirmary as a case of fungoid disease of the face. The lad became my patient. Bleeding was still going on, and he looked pale; it therefore became necessary to know at once what the disease really was. The coverings were all taken off, and the part well sponged. The swelling felt "doughy;" it wanted the hardness of scirrhus and the soft elastic feeling of fungus. In the centre of the cheek was an ulcerated opening, through which dark blood was oozing at the time. On passing a finger through the opening, it appeared to enter a large cavity filled with

coagula. On withdrawing the finger, it was covered with blood and small coagula. I determined at once to lay open this cavity freely, to clear away its contents, and know what it really was. This I did immediately; and, the exposed parts having been well cleaned, an artery was found bleeding, which I tied. It seemed to be either the facial or one of its primary branches.

The conclusion to be arrived at is, that the instrument used in opening the supposed abscess, wounded the artery. Blood issuing from the puncture, the wound was immediately closed, and constant pressure kept up to stop the bleeding, the coagula being kept in by this pressure. The swelling, no doubt, was from that form of inflammation, in which there is more fluid than solid exudation, giving a deceptive feeling of suppuration. We have often seen these swellings opened when there was no pus formed. I think this case gives us a caution not to be too hasty in making a diagnosis of malignant disease; and it also confirms a most useful rule of practice, which is, where pressure fails to arrest bleeding from a deep surface or cavity, at once to lay the parts open freely, and thus ascertain whence the bleeding comes, whether from one vessel which can be tied, or from a number of minute ones, where stypties can be applied. Cases occur where bleeding goes on a few days from a stump, say after amputation of the thigh. A large gush of blood comes on suddenly, and is supposed to come from the main artery, so as to lead the surgeon to think of tying the vessel above the wound. Let the wound be freely laid open, if necessary, adhesions separated, and the entire surface exposed to view. There may be some oozing of blood going on, or, more often, the mere exposure to air at once arrests any further hemorrhage; and in some cases the exposed surface of the stump looks like sodden skin, showing a want of vital power and consequent failure to throw out granulations—the only process by which the wound can be filled up, aided of course to some extent by vital contraction in the surrounding parts. Any stimulating dressing in such a case as this now brings on a healthy condition on the face of the wound. A case precisely similar to the one described occurred in the infirmary, where more than a pint of blood was lost in a gush. The tourniquet was at once applied, and I was sent for. By the advice of a very experienced colleague (the late Mr. Lowe), the artery was not tied, but the stump was opened in the way described. Not a drop of blood could be seen, merely the sodden surface just described. The large bleeding must have been from the surface; it was kept in by the dressings, had accumulated until the wound was mechanically distended by the large amount of fluid and could contain no more, when it suddenly burst through the coverings; and this led to the supposition that the main artery had given way.

In both these cases the wound healed rapidly under the usual applications, and without the use of carbolic acid or an invasion from those "septic germs" supposed by some to be such potent agents for mischief.

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A Case of Peri-cæcal Abscess.—(Under the care of Sir H. Thompson and Mr. Christopher Heath.)—In a previous number of this Journal (Dec., 1870, page 171), we alluded to the case of a youth, about twenty years of age, in whom Mr. Heath, in the absence of Sir H. Thompson, had opened an abscess which was pointing between the anterior superior spine of the right ilium and the mesial line of the abdomen; and stated that the incision was followed by a copious and forcible stream of offensive pus, the withdrawal of a large shred of sloughing cellular tissue, and finally by an alarming flow of venous blood, which was only arrested by filling, with lint soaked in perchloride of iron, a large cavity which was found to exist beneath the situation of the incision.

The further progress of this case, we learn from *The Lancet* (Feb. 11, 1871), was as follows: During the night following the operation some feces escaped from the wound. Two days afterward the plugs of lint were removed, and the cavity was washed out with a solution of carbolic acid (1 in 40), and refilled with fresh

plugs soaked in the same preparation. Notwithstanding the passage of a firm motion by the rectum, portions of fecal matter continued to be discharged through the wound. On the fourth day, the patient showed signs of increasing weakness, and complained of frequent faintness. The wound, which still gave passage to feces, was dressed as before. On the fifth day he felt better. On the sixth the wound gaped widely, and some large sloughs were removed. The cavity presented a red granulating surface, and contained more sloughs. Feces were passed daily by the rectum as well as by the wound. The cavity was directed to be washed daily with the carbolic solution. By the ninth day it was clear of sloughs, and when it was not full of feces, its surface could be seen to consist of granulations. On the eleventh day the patient appeared to be getting weak. He died exhausted on the twenty-second day, the fecal discharge from the wound having recurred to the last.

At the post-mortem examination there was found, in the right iliac fossa, the sac of an abscess which was bounded on the outer side by the iliacus muscle and the iliac bone—the surface of which was bare within two inches from the crest—on the inner side by the cæcum and some thickened peritoneum, and in front by the abdominal walls. The finger could be passed anteriorly into a sloughy cavity between the bladder and the pubes, and posteriorly between the rectum and the bladder. The pus had penetrated into the subperitoneal tissue, but had been arrested in its course towards the perineum by the recto-vesical fascia. The whole sac of the abscess and the surrounding parts were removed *en masse*, but a careful examination failed to discover the source of the hemorrhage. In the inner wall of the abscess were situated two large openings, which communicated with the cæcum, and through which prolapsed the mucous membrane of the gut, of a dark red colour, each portion presenting very much the appearance of a prolapsus ani. On opening the intestine, no scars or other traces of recent ulceration could be seen. Beyond these openings the gut was contracted but healthy. The small intestine was healthy.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Meningitis treated by Bromide of Potassium; Recovery.—By Robert Horner, M. D., of Gettysburg, Pa.—On the 19th of last December, I was requested to see a child eighteen months old, of a scrofulous diathesis, with convulsions. The paroxysm was slight, but was followed by a violent attack of pneumonia. After a few days the pneumonia yielded to treatment, and the child seemed to be recovering, when meningeal inflammation set in. There was acute pain in the head, with great restlessness alternating with stupor. The head was hot, the stomach irritable; the stools green. The usual mode of treatment was adopted and continued for some days without making any perceptible impression on the disease. The case was becoming hopeless. The stupor was more intense, verging on coma; the eyes were turned up, the lids half closed, the pupils dilated, pulse less frequent. The child was now put on the bromide of potassium, one half grain every three hours, and continued for two days without any change in the symptoms, the child, however, not getting any worse. The dose was then increased to two grains, when, after continuing it for twenty-four hours more, there was a marked change for the better. The bromide was continued in the two-grain doses until the head symptoms had all subsided. The recovery was complete.

Placenta Prævia.—Dr. D. Humphreys Storer reported to the Boston Society for Medical Improvement (*Boston Med. and Surg. Journal*, Jan. 12, 1871) the following case of this to show how satisfactory, in some alarming cases, is the treatment proposed and practised by the late Prof. Simpson.

"You are aware that in cases of placenta prævia, when the os uteri is so undilatable as to render it utterly impracticable to introduce the hand into the uterus for

the purpose of turning, and the hemorrhage is urgent, Prof. Simpson has advised and practised passing the finger within the os as far as possible, and separating the placenta—thus breaking up the connection between mother and child, and checking the hemorrhage at the loss of the life of the latter.

"I was called, a few weeks since, to a lady in the eighth month of her pregnancy with her eighth child. I had attended her in seven of her confinements; she had always done well. Now, without any premonition, while sitting with her family, she was alarmed by a profuse hemorrhage from the vagina. She was immediately removed to her chamber, and I was sent for. Arriving at her house in a very short time, I found her in bed, literally blanched by the loss of blood, gasping for breath, and her pulse scarcely perceptible. Upon raising the bedclothes, the hemorrhage was found to be extreme. Introducing my finger into the vagina, the os was felt to have scarcely commenced dilating; the extremity only of the finger could be passed into it. I immediately sent for ergot, and felt I must act at once if my patient was to be saved; the tampon seemed out of the question, as the little additional blood which would inevitably be lost previous to its being checked by this method, might destroy her. Accordingly, while stimulants were being administered, I endeavoured to dilate the os; and by considerable continued effort was enabled to pass my finger into it, and to separate the placenta. Upon obtaining the ergot, half of a drachm of the powder was exhibited in infusion. Almost immediately after the placenta was delivered, the bleeding lessened, and soon entirely ceased, and with its cessation my patient began to rally, and my fears to diminish. In the course of half an hour ergotine pains commenced and continued quite active for some time, when, having ceased, and the os being now sufficiently dilated, the forceps were applied, and the child readily delivered. No untoward symptom supervened after delivery, and the lady was as well at the expiration of a fortnight as she had been at the same period in previous confinements."

Death from Chloroform.—In the No. of the *Nashville Journal of Medicine and Surgery* for February, 1871, Dr. W. T. Briggs reports a case of this. About two drachms of Squibb's chloroform was administered on a towel, to produce anæsthesia. The patient died during the operation (dissection of the scalp).

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The Profession and Politics.—It is announced in the No. of the *National Medical Journal* for January, that "It is contemplated to establish in Washington City a National University, embracing a literary college, besides departments of law, physics, and polytechnics, in which the highest order of talent will be employed in the various departments, and the most elevated systems of education adopted; instruction to be *free*, and accessible to both sexes."

It will be an evil day for legitimate medicine, and a bright one for quackery, when this event shall be accomplished. To trust to politicians for the advancement of scientific medicine would be to seek such protection as wolves give to lambs. Independent of the utter inability of politicians to judge of medical qualifications, there are so many motives which would influence them—as, the desire for popularity, the wish to oblige constituents, the gratification of ignorant prejudices, etc. etc., that judicious selections of Professors could never be made. Noisy and boisterous pretenders would always triumph, in their application for appointments, over solid, sterling, modest merit. Further, the practitioners of every irregular system would urge their claims to have their dogmas taught by Professors, and doubtless many of them could exercise sufficient political influence to succeed. Thus the professors of scientific medicine and the votaries of every system of empiricism would be placed on a level, and scientific medicine itself degraded.

In the report of the proceedings of our *National House of Representatives* on the 7th of last month (February) it is stated that—

"Mr. Ketcham presented resolutions of the Homœopathic societies of Duchess and other counties in New York, in favour of

the establishment of a *National University at Washington*, wherein homœopathy as a system of medicine, shall be recognized.

"Mr. Dawes presented a petition from citizens of Springfield, Mass., for the same purpose."

Other movements of a similar tendency have been made, and they foreshadow what may be expected should our medical schools fall under the control of State or National legislators.

We trust that every thoughtful physician will exert all the influence he may possess, to prevent the consummation of a scheme which would be as baneful to the community as to medical science.

—

Society of the Alumni, Medical Department of the University of Pennsylvania.—The Alumni of the Medical Department of the University of Pennsylvania will celebrate the anniversary of the institution of the Society by a banquet, to be given at 6 o'clock P. M., March 13th, at the Hall of the Department of Arts of the University. The subscription ($5 00) is not limited to members of the Society alone, but is open to all graduates of the Medical Department who are in good standing. Subscriptions should be sent forthwith to the Treasurer, Dr. Tyson, 332 South Fifteenth St.

The Annual Business Meeting of the Society will be held on Commencement day, March 14, at 5 P. M.

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Alumni Association of the Jefferson Medical College.—The annual meeting of the association will be held at the college on Saturday, March 11, at 12 o'clock. The address of the President, Prof. Samuel D. Gross, will be delivered at the college in the evening, at 7 o'clock precisely; after which the Alumni dinner will be served at 1105 Walnut Street. Members are invited to the meeting and the delivery of the address, and also to participate in the dinner, tickets for which, at five dollars each, may be obtained of the committee—J. Ewing Mears, M. D.; Samuel W. Gross, M. D., and Richard J. Dunglison, M. D.

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The Georgia Medical Companion.—We acknowledge the receipt of the first number of this journal, which was issued in January of this year, at Atlanta, and is announced to appear monthly thereafter. It is edited by Drs. T. S. Powell and W. T. Goldsmith. We with pleasure place it on our exchange list.

—

Obituary Record.—Died, of apoplexy, in New York, January 29th, in the forty-fourth year of his age, George Thomson Elliot, M. D., Professor of Obstetrics and Diseases of Women and Children in the Bellevue Hospital Medical College, New York. Dr. Elliot graduated at the University of New York in the spring of 1849, and was elected, in 1861, to the Professorship which he held at the time of his death. As a clinical teacher and lecturer he was eminently successful and popular, and as a writer he is widely known to the profession as the author of the "Obstetric Clinic" and of various papers contributed to our periodical literature.

FOREIGN INTELLIGENCE.

Death after Inhalation of Chloroform.—A robust man, æt. 28, died recently at the London Hospital, about three minutes after the completion of an operation for fistula in ano, which had occupied not more than two or three minutes. He had taken chloroform without any unusual difficulty, and had lain during the operation on his left side; his pulse had been good throughout. The operation being completed, he was replaced on his back, and immediately ceased to breathe, and became livid in the face. Meanwhile the heart continued to beat regularly, though feebly. After artificial respiration had been employed for a few minutes, he breathed normally for a few seconds, and then both breathing and pulse ceased altogether. Artificial respiration was carried on for forty minutes without avail.

The heart was found to weigh fourteen ounces; the left ventricle, the walls of which were pale and flaccid, and covered externally with only a thin layer of fat, was full of dark fluid blood; the mitral orifice freely admitted the tips of four fingers. The muscular fibres of the heart were found under the microscope to contain an abundance of fat-globules. The lungs were congested and œdematous;

the pulmonary artery was full of blood. The stomach was empty and healthy; the spleen large and soft. The brain and kidneys were normal. The blood was everywhere fluid.—*Lancet*, Dec. 24, 1870.

Another case of this is reported in the *Lancet* for Jan. 28, 1871, as having occurred at the Westminster Ophthalmic Hospital. The patient, aged fifty two, had a drachm and a half of chloroform administered to him upon a cone of flannel, to produce anæsthesia, while Mr. Power performed an iridectomy upon him. After the completion of the operation, he began to breathe stertorously, and in a few minutes later died.

—

Sympathetic Nervous Trouble from the presence of a Tænia.—Two cases mentioned by Dr. Maurin (in *Sud Médical*, No. 5, 1870, and *Lyon Médical*, April 24, 1870) are interesting in this, that they might have given rise to a diagnosis of troubles of the nervous centres.

The first patient was a clerk, aged forty-two, who for fourteen months had experienced more and more serious illnesses. At first he suffered from dull pains in the epigastrium; these pains after a while took on the character of an intense gastralgia, with inexplicable remissions and exacerbations.

A few months afterward he had some vertigo complicating the gastric pain. Finally, for eighteen months past, the gastralgia has yielded, but has been followed by a continued sensation of vertigo, a fixed pain in the nape of the neck and between the shoulders; sensation of falling forward when the patient walks up or down any incline; sensation as of a soft body, like a cushion, under the feet during the walk; fear of an imminent death; sudden inclination to commit suicide.

The second patient was a physician, who experienced all the symptoms of a cerebral congestion; cephalalgia, troubles of the intellect, incomplete amnesia, impediment of speech; the patient, being gouty, had fear of a metastasis; but a few articulations of tænia having been passed, the diagnosis was made, and as in the preceding case, a dose of kousso, by producing the expulsion of a tænia, caused at the same time all the symptoms to disappear.—*New York Med. Journal*, Feb. 1871.

—

Cyanide of Potassium in Pulmonary Affections.—Dr. G. Mazza (*Annali Universali*) has found the cyanide preferable to hydrocyanic acid on account of the great volatility of the acid, and its consequent variability in strength. He describes it as a sovereign remedy in many forms of lung disease, but especially valuable in tuberculosis. In order to combat the sleeplessness due to the harassing cough, he combines the cyanide with small doses of morphia. In the early stages of the disease, he has frequently seen complete recovery, and when more advanced a mitigation of the symptoms is apparent.—*The Doctor*, Jan. 1871.

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Treatment of Chorea by Ether Spray to the Spine.—Dr. John Rose reports (*Lancet*, Dec. 10, 1870) the case of an anæmic girl, aged thirteen years, who had had rheumatism, but without heart affection, who was successfully treated by this means. The spray was applied along the spine, four or five minutes each time; and after fifteen sittings a very marked improvement took place, followed by complete recovery.

Two cases have been successfully treated by the same method by Perroud, of Lyons. (See *Medical News* for February, 1870, p. 30.)

—

Fracture of a Rib from Coughing.—Mr. Miall, surgeon to the Bradford Infirmary, relates (*British Med. Journ.*, Jan. 7, 1871) the following case of this rare accident, of which eight cases are collected by Malgaigne.

A woman, æt. 53, in the seventh month of her first pregnancy, was under my care for severe cough, due to relaxed uvula, and perhaps also to her condition. She was somewhat anæmic, but not in extremely bad health, and not distinctly tuberculous, though the family history shows a tuberculous taint. On the evening of March 3d, 1869, after a violent paroxysm of cough, she felt something give way in her side; and when I saw her a few hours afterwards, she described the grating on

inspiration, and other symptoms, in a way that made the nature of the accident unmistakable. On examination, the tenth rib was found broken transversely, a little anterior to the tubercle. The fractured ends were prominent. The case went on satisfactorily under ordinary treatment; and there has been no recurrence of the accident either during labour or since. There was no reason to suspect any other cause for the fracture.

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The Sulphites and Hyposulphites of Soda or Magnesia.—Dr. Ronzani (*Annali di Medicina*, Nov. 1870) gave these salts, proposed by Polli as the most trustworthy antiseptics, a fair trial in malarious intermittents, and found them to answer remarkably well. He administered the sulphite of magnesia in doses varying from 30 to 60 grains, three or four times a day. Out of one hundred and twenty patients suffering from marsh fever, two-thirds were free from attacks in a very short time; the remaining third had quinia and other drugs besides the sulphite. Of course Polli and the numerous Italian physicians who give the sulphites, believe in the fermentative nature of the poison of malaria. Dr. Ronzani, in his article, makes judicious remarks as to the action of the toxic agent. He used hyposulphite of lime especially to treat the ague-cake, giving ninety grains a day at the beginning, and increasing the dose by fifteen grains every second day for a fortnight. In obstinate cases, blisters over the enlarged spleen, and quinia, iron, and rhubarb internally. The author dwells especially on the low price of the sulphites. We do not suffer much in this country from marsh fever; but we have to contend against many diseases the origin of which is poisoned blood. It would be of advantage to give these sulphites and hyposulphites a fair trial, taking care that the salts are pure, and have not run into sulphates.—*Lancet*, Feb. 4, 1871.

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Glycerol of Pepsine.—Von Wittich (Pfluger's *Archiv*), and after him Michael Foster (*Nature*), have ascertained that glycerine extracts of the mucous membrane of the stomach possess peptic powers more complete and reliable than those made at the present time; and that the amylopeptic ferments of the pancreas and salivary gland may be similarly extracted with advantage. This hint will not, we anticipate, be lost on physicians and pharmaceutists. The glycerine extracts are said to be at once more active, palatable, and stable.—*British Med. Journal*, Jan. 28, 1871.

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Iodized Milk.—From Hoffman's most admirable report on the "Progress of Pharmacy, 1869," we make the subjoined extract, which has a practical value for the physician:—

Iodine and Milk.—It is well known that milk takes up iodine, disguising its taste, smell, and colour completely; since iodine is antiseptic, iodized milk keeps for some time. Dr. Hagar calls attention to this fact, and suggests that this, perhaps, is the mildest form of administering iodine. Its therapeutic effect seems to be equal only to about one-fifth of the iodine.

Hagar thinks iodized milk will soon become a favourite form of administering iodine, and suggests the following mode of preparation; one part of iodine dissolved in ten parts of alcohol, admixed with ninety parts of fresh warm cow's milk.—*Med. Press and Circular*, Jan. 15, 1871.

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A New Iodine Paint.—Dr. J. Waring-Curran recommends (*Med. Press and Circ.*, Aug. 3, 1870) the following paint as an excellent application in cases of glandular enlargements and scrofulous diseases, wherein iodine is called into requisition. Rub down half an ounce of iodine and a like quantity of iodide of ammonium in a Wedgewood mortar, and gradually dissolve it in twenty ounces of rectified spirit; to this add four ounces of glycerine, shaking well the solution. Iodide of ammonium, the author thinks, is a more powerful absorbent than iodide of potassium.

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Analysis of Samples of Hydrate of Chloral met with in Commerce.—The *Brit. Med. Journal*, Feb. 4, 1871, gives the analyses of ten different samples of chloral hydrate collected from different sources.

The test that was adopted for the purpose of determining the relative quality of various samples of hydrate of chloral, is based upon the reaction taking place when ammonia is mixed with a solution of hydrate of chloral, heated in a closed tube, and left at rest for some time. By this reaction, the hydrate of chloral is converted into chloroform, which separates in an oily layer at the bottom of the tube, while formate of ammonia remains in solution as a brownish watery liquid above it.

In a suitable tube, the volume of the chloroform produced in the reaction may be measured off. Chemically pure hydrate of chloral treated in this manner yields 72.2 per cent. by weight of chloroform; and, since the specific gravity of chloroform, as compared with water, is 1 49, ten *grammes* of pure hydrate of chloral will yield 4.82 cubic *centimetres* of chloroform.

The result of these analyses shows that there is a variation of quality in the hydrate of chloral of commerce, amounting, in some instances, to as much as 10 per cent.

—

Cocoa and Condensed Milk.—The English Condensed Milk Company (Lion Brand) have introduced into use a combination of cocoa and condensed milk, which is, in its way, perfect. A teaspoonful dissolved in a small cup of boiling water, makes on the spot a cup of excellent, pure, and delicious cocoa, or chocolate, as you may please to call it, which requires neither further sugar nor milk. Made of pure cocoa and condensed milk, with an adequate addition of sugar, and prepared in small tins which can be kept for any length of time, it recommends itself for a great number of useful purposes, which immediately suggest themselves—in the sick-room, whether for patient, or nurse, or weary doctor; in hospitals, ships, camps; in the study of the night-worker, the bachelor's cupboard, the emigrant's stores, the army canteen, the volunteer camp; for yachting and exploring parties; for fishing, shooting, and picnic excursions, at home and abroad, it will be alike grateful and convenient. It is a very happy idea, well carried out; and will, we expect, achieve an immediate and extended success.—*Brit. Med. Journal*, Jan. 28, 1871.

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Smallpox Epidemic in England.—We have already called attention to the existing smallpox epidemic in England, and must again urge upon our sanitary authorities to take active measures to prevent its extension to this country, and the most important and effective of these is a general and careful vaccination of all who are unprotected, and revaccination of those in regard to whose protection there can be the least doubt.

During the weeks ending Jan. 7, 14, 21, and 28, the number of deaths from smallpox in London was respectively 79, 135, 188, and 153.

"Smallpox," it is observed in an editorial in the *Med. Times and Gazette*, Feb. 4, 1871, "is one of those diseases which recur in more or less distinct cyclical periods—its prevalence being capable of being represented by a waved line, in which the summit of each wave is separated from the neighbouring summits by an interval of about four years. The last epidemic wave was observed in 1866–67; it rises now again in 1870–71. Judging, then, by experience, a wave of epidemic prevalence was to have been anticipated; but the question remains unsolved why it should this time have risen so much higher than has recently been customary. It must have a cause; its discovery is the task which scientific Medicine has before it. The epidemic being due in 1870–71, it was further to be anticipated that it would begin to exhibit itself towards the close of the year. Some tables, published by Dr. Ballard, in one of the Reports of the Medical Officers of the Privy Council, show that "the rule has been for smallpox to prevail least in the summer, to increase through the autumn and winter, and to prevail most in the spring of the year." He gives the months of March, April, and May as those in which the disease prevails most. If this rule holds good in the present instance, and unless some decided impression be made by protectionary measures upon our population,

we have not yet seen the highest point by a good deal, which this epidemic is destined to reach. At present there is no sign of early diminution."

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Lessons of the Smallpox Epidemic in London.—The editor of the *Lancet*, in a leader on this subject, makes the following important remarks: "Two or three lessons cannot be too deeply impressed on practitioners. First, that the great secret of vaccinating well is to do it *copiously* as regards the amount of lymph employed; the best vaccinators that we see bathe their lancets freely in lymph before using them, and repeat the bathing process in the course of the operation. Secondly, that the more numerous the vesicles, the more perfect is the protection of the patient. But that, thirdly, no primary vaccination should be relied on in epidemic times for persons above the age of puberty. The larger our experience, the more does it point to the importance of revaccination. A case has been reported to us in the course of our recent investigations, in which smallpox occurred to the mother of an unvaccinated baby. The baby was quickly vaccinated, and escaped. All the adults in the house submitted to revaccination but the sister, who refused; she alone took the disease, and she died. Smallpox was introduced into St. George's Hospital, and continued to spread until all the patients were revaccinated. After the complete revaccination of the patients no fresh cases occurred. If a little of the money that has been spent in procuring distant and incomplete hospital accommodations had been spent in spreading vaccination and revaccination during the last few weeks, there is little doubt that the disease would have been much more effectually arrested. Practitioners during the present epidemic are impressed with the degree to which revaccination takes. In many cases the vesicles seem to be as perfect as in primary vaccination. The great secret of successful revaccination, as of vaccination, is the insertion of fresh lymph and plenty of it. Let us have a complete end of poor, scanty, dry vaccination, whether primary or otherwise.—*Lancet*, Feb. 4, 1871.

A Significant Fact in regard to the Protective Power of Vaccination.—During these times of scepticism as to the protective virtue of vaccination, it may be of some interest to learn a little fact which has lately come to our knowledge, on the accuracy of which perfect reliance can be placed. A military surgeon having recently had occasion to examine a large number of English recruits, found that 60 per cent. of lads unprotected by vaccination had been the subjects of smallpox, as against 1.90 per cent. of protected recruits who bore traces of smallpox. Remembering that these are men who have escaped any permanent damage from the disease, what must be the percentage of attacks in unprotected cases generally?—*Lancet*, Feb. 4, 1871.

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Antiseptic Dressing.—Dr. Crace Calvert, F.R.S., of Manchester, having been requested to carbolize a quantity of charpie for the use of the ambulances at the seat of war, found that charpie was unsuitable for the purpose; and, after trying several textures, finally hit upon oakum as the most excellent. The oakum is first soaked in Burgundy pitch, and then rendered antiseptic by the addition of carbolic acid. This application has been a good deal used at the Manchester Infirmary, and with good results.—*British Med. Journal*, Jan. 21, 1871.

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Cancerous Inoculation with the Trocar.—Dr. Reineke has published in Virchow's *Archiv* (51 Bd., 3 Heft) two cases of abdominal cancer, in which paracentesis was used. Both cases ended fatally, and it was found that cancerous tumours had formed along the track of the trocar. The author considers this as a regular inoculation, and thinks that, in appropriate cases, experiments should be undertaken. The tumours here alluded to are very different from the cancerous deposits which may take place at a distance from the region principally invaded by carcinoma; they were evidently the result of direct traumatic contamination.—*Lancet*, Jan. 14, 1871.

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CLINICS.

CLINICAL LECTURES.

Abstract of a Clinical Lecture on Tracheotomy. By GEORGE BUCHANAN, M. D., Lecturer on Clinical Surgery, Glasgow Royal Infirmary, &c. &c.

GENTLEMEN: I propose to call attention to-day to the operation of tracheotomy, with special reference to its performance with the view of saving life in the later stages of croup and diphtheria. These two diseases are characterized by the effusion of a false membrane on the mucous surface of the air-passages; in croup, the lymph being deposited first in the trachea, with a tendency to spread down into the bronchi, sometimes up into the lower orifice of the larynx; in diphtheria, the deposit being seen first on the fauces, tonsils, and pharynx, with a tendency to spread down through the upper opening of the larynx into the trachea, and even into the bronchi. When in either disease the effusion of lymph is excessive, the respiration is impeded to such a degree that the patient dies of suffocation.

I shall not take up your time with any general remarks on the nature, causes, and symptoms of these affections, nor give you any indications for their treatment in the earlier stages; for, though I have very well defined ideas on these subjects, most of you are aware that both in teaching and practice I confine myself exclusively to surgical cases. In consequence, I have no opportunity of observing the effects of remedies, except such as are afforded by the reports of those medical men who request my assistance in the more advanced stage. But there is one point to which I beg most earnestly

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to call your attention—it is that, in both of these diseases, but more especially in diphtheria, and more manifestly when they occur as epidemics, they may exist in one of two types, the sthenic or asthenic. In the asthenic, the tendency is to cause death by exhaustion—failure of the vital powers; in the sthenic, by suffocation. You will hear it sometimes stated that because diphtheria is a general disease—somewhat like scarlet fever—and the lymphy effusion but the local manifestation of it, therefore it is unphilosophical to propose tracheotomy in such a case; but you will remember that this operation has never been suggested with any intention of cutting short the disease, nor ought it to be performed when there is great prostration. It is in the sthenic form alone that it is admissible. And what I would urge on you is this, when you find that your patient, whatever be the original disease—croup or diphtheria—is not improving by the treatment you have been adopting; when you find that the effusion is going on to produce suffocation; when the tendency is to death by apnœa more than by exhaustion, then you ought to step in and perform tracheotomy for the purpose of preventing immediate death, and so give longer time for the patient to live through the disease and ultimately throw it off. Nay, you will find, after a comparatively limited experience, that you will be able to recognize early in the progress of a case whether the tendency is to apnœa or exhaustion; and I would be inclined to urge my own experience as a reason for performing tracheotomy in the class of cases in which it will inevitably be required, before the struggle for breath has exhausted the strength of the sufferer, so rendering the operation less successful than it might have been.

In short, let not the name of the disease deter you; but, when you find a patient clearly progressing to death by suffocation, while the vital powers are otherwise vigorous, my maxim for you would be, open the windpipe and ward off the impending death, whatever be the ultimate result; you have done your duty and saved life, at least temporarily. I admit that it is sometimes a very nice point to decide when to interfere and when to refrain, and especially to discover when the effusion has spread down into the bronchi or bronchial tubes, in which case the operation would be useless. Percussion of the chest and the sibilant *râles* discoverable by auscultation are valuable aids to diagnosis; but there is one most characteristic sign which I find a sure and ready guide to distinguish between dyspnœa depending on pulmonary occlusion, whether congestive or bronchial, and that depending on tracheal obstruction—I allude to the observation of the respiratory movements. When the obstruction is in the larynx or trachea, the powerful attempts at respiration will be plainly visible, and their inefficacy will be evidenced by the drawing in of the costal cartilages and the intercostal spaces. When this is well marked and increasing, the pulse moderately good, it is a proof of the vigour of the vital powers, and is a clear indication for tracheotomy.

The steps of the operation are very easily indicated, but very difficult in the performance. The great maxim is, "operate leisurely and without hurry." The patient having been put under the influence of chloroform—a very great assistance in this operation—an incision is to be made about an inch and a half long from half an inch below the cricoid cartilage downwards. Layer after layer of the cellular tissue is to be divided till the trachea comes into view. This, which is easily stated, is a troublesome matter, owing to the perpetual movements of the trachea and the bulging into the wounds of veins, cellular tissue, and in children the apices of the thymus gland, all of which must be held aside with retractors. Any vessel which bleeds must be tied; and it must be a principle that the second stage of the operation is not to be undertaken till the white rings of the trachea are clearly seen at the bottom of the wound. A sharp hook is now to be fixed in the upper part of the trachea brought into view, and the knife plunged into it—the back of the knife being towards the larynx—and the incision made half an inch long. A pair of closed dress-

ing forceps are now to be introduced into the slit and opened, on which there will be a violent struggle, then a forcible expiration expelling quantities of false membrane and viscid mucus; and presently the patient will lie quiet, breathing tranquilly through the opening. The silver tube is now to be introduced, and the operation is completed. The only special precaution which I adopt in the after-treatment is to order the air in the apartment to be kept moist by steam from a kettle, or by some other means.

The following case illustrates these points very well:—

William S., aged 7 years, when convalescing from scarlet fever, had an attack of tonsillitis. The palate and tonsils became covered with a white exudation, and the voice became hoarse. After a few days he improved so much that there was no anxiety about him, when on the 12th January there was considerable difficulty in breathing and a hoarse barking cough. The white patch was to be seen on the tonsil, evidently extending downwards. On the 13th he continued in the same state, but on the 14th the symptoms had increased in severity so that Dr. Pirie, the medical attendant, requested me to visit him in consultation. When we saw him, however, the dyspnœa had become less urgent, so that we thought that he had a hope of recovery without operation. On the 15th all the symptoms became aggravated, and when I saw him in the evening with Dr. Pirie, it was quite evident that the struggle for breath would soon wear him out. The pulse was fair; he could swallow well; but the fits of dyspnœa were so frequent and urgent that he was tossing about, gasping, and begging to be relieved. An examination of the chest showed most clearly that the obstruction was in the larynx or trachea, and that the effusion had not extended into the smaller bronchi. The muscles were acting very powerfully, so that at each attempt at inspiration the sternum, costal cartilages, and intercostal spaces, were violently pulled inwards. The effort to inspire was evidently very strong, but there was hardly any room for air to pass; a clear indication for opening the windpipe to admit the air.

The nature of the operation having been explained to the parents, they committed the child to our care to do what we thought best for it. The assistance of my friend Dr. Smart having been procured, I proceeded to perform tracheotomy precisely as before described, and with the same result. The child, who before was tossing about in an agony of dyspnœa, was soon breathing with perfect tranquillity through the tracheal silver tube.

I need not describe the progress of the case from day to day. Four or five of my students most kindly volunteered to be with the patient for the first forty-eight hours, during which time the child was never left without skilled attendance, Dr. Pirie visiting two or three times a day. The result was most satisfactory. The tube was removed on the eighth day, and after that the child made a rapid recovery.

Postscript.—As an appendix to the above abstract, I may state that I have now performed tracheotomy in thirty-nine cases; of these thirteen recovered, or one out of every three operated on. As all those operated on were considered to be in a hopeless state, it may be concluded that thirteen lives were *saved* by the operation.—*Brit. Med. Journal*, March 4, 1871.

HOSPITAL NOTES AND GLEANINGS.

Bronchitis, with Dropsy, etc.—At the Glasgow Royal Infirmary, Dr. W. T. Gairdner had under treatment lately a male patient, aged forty-seven years, who suffered from the following complication of diseases: bronchitis, with dropsy, albuminuria, hypertrophy of left ventricle of heart, degenerated arteries, and arcus senilis.

On admission to the Royal Infirmary the patient was treated for bronchitis; subsequently a minute examination revealed puffiness of the eyelids, legs, feet, and back. The specific gravity of the urine was 1.012, albuminous, and contained granular tube casts; muscles were flabby, complexion pallid, and much flesh had been lost. Further examination showed arcus senilis in the corneæ, a tortuous and

resistant state of the anterior temporal arteries, of both radial arteries, and of thyroid axes; also considerable induration of the superficial femoral of the left side. These circumstances combined led to a careful examination of the cardiac region. Here percussion was difficult, owing to the presumed overlapping of emphysematous lungs, and effusion into the pleura diffused in the left lateral region. Hypertrophy of the left ventricle of the heart was diagnosed some days previously, and the facts recorded with care. At *that* date the cardiac apex beat was most strongly felt in the fifth intercostal space, and feebly in the sixth, from an inch and a quarter to the left of a vertical line of the nipple. Both these points had been marked with nitrate of silver. When the patient had been placed on his left side the impulse of the apex could be followed for two inches to the left of the line of the nipple. The left margin of the cardiac dulness was in accordance with the more remote of these situations; the upper margin passed through the nipple affording evidence of a lower position of the heart, or of pulmonary encroachment. The transverse measurement of the surface, over which dulness extended, was six inches. There was no fever; pulse, 70; liver and spleen revealed no distinct abnormal states.

Cream of tartar in electuary, and a stimulating mixture, containing spirit of chloroform and camphor mixture, had been administered from October the 14th to November the 1st, under which treatment the patient improved. At this date the bronchitis increased, but was relieved by the administration of cream of tartar in the form of drink. In October the urine averaged seventy ounces daily; during the relapse of bronchitis sixty ounces daily. It increased subsequently to seventy-three ounces, and on the 12th of November the patient passed one hundred ounces in twenty-four hours. The patient's condition seemed to improve in a ratio with the increased flow of urine.

On the 12th of November the sounds of the heart, though not much altered, nor free from murmurs, were in unison with the idea of hypertrophy of the left ventricle, yet slight alterations were observed in many phases of the case. The apex beat was appreciable at about half an inch nearer the nipple than the point previously diagnosed. No impulse could be detected in the sixth intercostal space, and dulness on percussion was correspondingly altered. The nitrate of silver marks, and the distinct character of the apex beat on the second, though not on the first examination, led to the inference that either a diminution in the size of the heart had occurred between the examination made on the 1st of November and that made on the 12th of November, or that the lung by being less expanded with air had permitted the heart to rise up in the thorax, and, consequently tilted the apex nearer the nipple.

Up to the time of his bronchial attack the patient considered himself strong and healthy, and the points indicating disease of heart, arteries, and cornea were only discovered by a full and complete examination.

The marked improvement in this case under diuretics, and the very curious evidence of that improvement made manifest by the condition of the cardiac region, are worthy of attention and especial notice; and, in estimating the latter, it ought not to be forgotten that the over-expansion of the margins of the lungs had a tendency to displace the heart downwards, and that the altered position of its apex may not be at all attributed to the size of that organ. In such a case, however, dulness should have extended and not retarded.

Bearing in mind all the points, Dr. Gairdner inclines to the belief that the hypertrophied or dilated left ventricle had become reduced in size, and acquired more control over its contents, influencing the improvement in all other symptoms.—*The Doctor*, Jan. 1871.

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Gum-elastic No. 4 Male Bougie removed from the Bladder of a pregnant Woman by Urethrotomy; threatened Abortion; Cure.—M. M., æt. 21, was admitted into University College Hospital, Dec. 15th, 1870. The patient had been engaged as a housemaid up to one month before admission.

She was in perfect health till about one month previously, when she commenced to have pain on passing urine, lasting a short time afterwards. The pain during micturition was of a pricking character, and after it she felt as if there were something more to come away. Lately, the urine had contained blood and matter. She passed it with considerable straining, and the pain remained the same. The pain was increased by movement. During the week before admission, she suffered from incontinence of urine, which escaped involuntarily every few minutes. She had occasionally passed fragments of grit. She said that she was quite regular in her periods up to two months before admission, since when she had seen nothing; but she was extremely reticent, and did not answer questions readily.

On admission, the patient was a fat anæmic girl. She was suffering from constant incontinence of urine, and the thighs and nates were slightly excoriated in consequence. Some of the urine which was collected was found to be alkaline, free from albumen, and depositing a considerable sediment composed of pus and triple phosphates. There was scarcely any blood. On December 16th, she passed a small gritty fragment, which was found to be composed entirely of phosphates. Mr. Erichsen sounded her, under chloroform, and found a calculus. It gave a distinct click when struck with the sound. It seemed to be of considerable size, was evidently phosphatic, and could be felt with the finger through the anterior vaginal wall.

On December 21st, the patient being tied up in the lithotomy-position, Mr. Erichsen passed a full-sized male median lithotomy-staff, and opened the urethra at the vaginal aspect, dividing the under-surface for about one inch. A pair of small lithotomy-forceps were then passed into the bladder, and the foreign body was removed. On examination, it was found to be a No. 4 male gum-elastic bougie, coiled up, and coated with phosphates to the thickness of about one-sixteenth of an inch. The ivory head was not covered with any deposit, and had doubtless been the cause of the distinct click heard on sounding. The wound in the urethra was brought together with silver sutures, and a catheter tied in. The patient was then removed to bed, and an India-rubber tube attached to the catheter to carry off the urine.

The patient went on well till December 25th, when some hemorrhage occurred from the vagina, which ceased after a slight loss of blood. This was repeated on the 26th and 27th, until the patient was much weakened by the loss of blood. It was then found, on further examination, that she was in the fourth month of pregnancy, and that abortion was threatening. She was transferred to the care of Dr. Graily Hewitt, under whose treatment the progress of miscarriage was stayed; and she gradually recovered, leaving the hospital in about a month after the operation.

Mr. Erichsen stated that this case was extremely interesting in a medico-legal as well as in a surgical point of view. Here was an unmarried girl pregnant, with impending abortion, in whose bladder a male gum-elastic bougie was found. There could be no doubt in the minds of any conversant with the practices that were unfortunately notoriously rife in this country—though less so than in some others—that the bougie had been employed for the purpose of procuring abortion; that it had been used by an unskilled hand; that the urethral orifice had been mistaken for the os uteri; and that the instrument, having slipped in, had occasioned the symptoms of calculus for which she had been admitted. His suspicions as to the alleged calculus being, or having for a nucleus, a foreign body, had been aroused by the reticence of the girl; but he had thought, as is very common in such cases, that the foreign body, whatever it might be, had been introduced to gratify sensual feelings, rather than with a positively criminal intent. Stone in the bladder was so rare in young women, that, when a calculous mass was found, it was almost invariably found around some extraneous body, such as a hair-pin, a piece of pencil, etc., that had been accidentally slipped into the urethra. In this case, the mode of introduction was

different; and there could be no doubt, from the nature of the foreign body and from the coexistence of pregnancy, as to the motives that had suggested its use. It had probably been in the bladder about two months, judging by the quantity of phosphates by which it was encrusted. The bougie, as usually happens, was coiled up into one mass; and the ivory handle, being free and uncoated, gave a clear and distinct click to the sound.

With respect to the operation, Mr. Erichsen performed urethrotomy instead of dilating the urethra, as he thought that, as the mass was rather large, the canal might be over-stretched, and incontinence would then result. The cut in the urethra was immediately closed by silver sutures. —*Brit. Med. Journal*, March 4th, 1871.

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Aneurism of the Axillary Artery; Ligature of the Subclavian.—G. M., a sailor, æt. 53, was admitted into King's College Hospital, under the care of Sir W. Fergusson, on January 18th, 1871, suffering from an aneurism of the right axillary artery.

On September 13th, 1870, as he was trying to reach something by stretching his arm through the meshes of a rope-ladder, he fancied he felt something give way. He took but little notice of this at the time. The next day, as he was ascending the rope-ladder, his foot slipped, and his arm, being above one of the cross-trees, was brought down upon it with great force, nearly the whole weight of the body being supported by the arm. Later on in the day he noticed, for the first time, that there was a pulsating swelling, high up on the inner side of the right arm, almost in the axilla; the swelling was about as large as a walnut. During the next fortnight he lost nearly the whole power of movement over the hand and forearm. Flexion and extension at the elbow became very weak; the power of extending the wrist and fingers was wholly lost, but slight power of flexion remained. Pronation and supination were impaired, though not wholly lost. The man experienced a dull aching pain in the ends of his fingers, but none in the seat of the aneurism. There was loss of sensation in the little finger and the inner side of the ring finger. On admission, the aneurism could be seen and felt on the inner side of the right arm. It projected about an inch and a half below the lower border of the pectoralis major, this part alone being visible, but strong pulsation could be felt through the muscles as high as to within half an inch of the clavicle. The tumour could not be felt above the clavicle. The pulse at the wrist was all but imperceptible. Pressure on the subclavian stopped the pulsation in the tumour, but it was difficult to compress on account of the man keeping his shoulder raised.

February 7th. There was little or no change in the aneurism; if anything, it was rather larger and more painful.

Operation.—February 8th. The patient having been placed fully under the influence of chloroform, Sir William Fergusson made an incision about four inches long about half an inch above the clavicle, and parallel with that bone through the skin, superficial fascia, and platysma. The external jugular vein then became apparent, and was drawn aside; by careful dissection, the omo-hyoid muscle was then exposed, loosened from its attachments, and drawn upwards and outwards by a blunt hook. At this time there was a little venous hemorrhage, which somewhat obscured the structures. After carefully dissecting a little deeper, chiefly with the handle of the scalpel, the margin of the anterior scalenus muscle was exposed, and then about half an inch of the artery. Sir W. Fergusson now passed the needle from below upwards, and, after trying its effect upon the aneurism, tightened the ligature upon the vessel. The wound was closed by sutures and dressed with dry lint. The pulsation in the aneurism was completely stopped. Not an ounce of blood was lost during the operation. On account of the great depth of the vessel, it was found necessary to enlarge the original incision twice during the operation, in a crucial manner.

March 1st. Up to the present time, the patient has not had a bad symptom; the tumour has become hard and more solid; the radial pulse is not yet percep-

tible; the ligature has not yet come away, but the wound is in a great part healed.—*British Medical Journal*, March 4th, 1871.

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Case of Primary Cancer of Liver.—Carcinoma of the liver, being usually preceded by cancer of other organs, is rarely met with as a primary affection. As a secondary deposit its occurrence is far more frequent; and Rokitansky has estimated that it is found once in the liver for every five instances of its presence in other parts of the body. The difficulties of diagnosis in the present case were increased by the absence of icterus, ascites, or œdema, and by the want of any distinct evidence of indurated protuberances in any part of the organ. In summing up the features of the case, Dr. Headland remarked that the enlargement could scarcely be attributed to cirrhosis, since there was no history of alcoholic intoxication, nor to albuminoid disease, as there was no evidence of caries, long-continued suppuration, or of either of the other usual coexistent conditions; abscess of the liver and hydatid cyst were excluded from consideration by the absence of pyrexia and of any circumscribed tumour; and, taking into consideration the rapidity of its growth and the presence of pain, he concluded that the enlargement must be due either to cancer of the stomach and secondary deposit in the liver, or, in spite of its rarity, to primary cancerous infiltration of the latter.

W. S——, aged forty, was admitted into Charing-Cross Hospital under the care of Dr. Headland, on the 12th of January, suffering from enlargement of the liver. He stated that for the last three months he had been gradually losing flesh and suffering from obscure pains in the right side. He always previously considered himself a strong, healthy man, and had never lost a day's work through sickness. Six weeks before admission he had been seized with sharp cutting pains, which made him feel sick, and compelled him to leave his work and go home. Since then he had been laid up. He had always been a temperate man, and had never had syphilis. There was no history of cancer in his family. He complained of constant pain, aggravated by every movement, and by the slightest touch. There were complete anorexia, and occasional vomiting; once or twice blood had been observed. The bowels were constipated and the motions clay-coloured. The urine had a specific gravity of 1027, and yielded a violet-coloured abnormal deposit on cooling. The area of liver dulness could be traced downwards to a line drawn from the umbilicus to the crista ilii on the right side, and to a line drawn from the umbilicus into the left hypochondrium to the region of splenic dulness. The percussion of the upper border gave the following limits: In the mammary line, dulness just above the upper margin of the fifth rib; in the axillary line, to the sixth rib; and in the dorsal line, to the upper border of the seventh rib. Palpation of the edge of the liver afforded no definite information, though there were a suspicious hardness and tenderness in the epigastric region; otherwise the liver felt uniform and smooth. Bronchial breathing was heard over the base of the right lung. The case remained under observation till the 3d of February, when the patient died. A few days before his death he became paraplegic.

On examination after death, the body did not present any distinct cachexia, nor was there œdema or ascites. On opening the abdomen, the liver at once came into view, reaching downwards below the umbilicus, and studded with large white excavated patches of the size of a crown-piece; these, towards the margin, were less distinct, and the liver-tissue was more equally infiltrated and less nodular. On section, the liver was studded throughout with circumscribed tumours of medullary cancer, some of which were undergoing softening. The weight of the liver was 9 lb. 5 oz. The base of the left lung was consolidated. The bladder was distended with urine; its mucous membrane much pigmented and eroded, owing, no doubt, to the alkaline urine secreted since paraplegia had come on. Careful search was made in the stomach, intestines, and lungs for other deposits, but these organs were, without exception, quite healthy.—*Lancet*, Feb. 25th, 1871.

Unilateral Anæsthesiæ without impairment of motor power, occurring suddenly in the subject of Heart Disease.—The following rare form of nerve-lesion came under Dr. Gray's notice early in January, at the Radcliffe Infirmary, Oxford.

W. B., æt. 62, ten weeks previously, while stooping to pick up a piece of wood, suddenly experienced a painful tingling sensation in the right hand, foot, and side of face. In the face the smarting was so severe that he thought he must have been stung by a bee. On drawing his hand across his face to wipe away the supposed bee, he found, to his surprise, that over the right half of his face, exactly up to the middle line of nose, lips, and chin, the skin was insensible to the touch. There was no headache or other cerebral symptom. After a few hours the foot quite recovered. At the end of two or three days the right hand and cheek ceased to tingle and smart, but did not regain their sensibility, and have not done so since. From the first there has been no loss of power in the affected parts.

On the occasion of his last visit (February 11), his condition was noted as follows: The palm and dorsum of right hand have their natural feeling, but, from the root of each finger to its tip, ordinary tactile sensibility is lost. A prick or pinch is felt, not as such, but as a scald. Their sensitiveness to heat or cold is exaggerated. Their electro-sensibility not tested. He can grip as strongly with this hand as with the other, but cannot use it for any delicate operation. Thus, in picking up a pencil off the table, the fingers fumble clumsily, and have to be guided by his eyes. (There is permanent contraction and rigidity of the palmar portion of the tendon of the middle finger; but he says this has existed for years, and attributes it to his former trade—shoemaking.)

Precisely the same phenomena of impaired and prevented sensation exist on the right side of the face, within the following limits—viz., forwards, as far as mesial line of nose, lips, and chin; upwards, along the lower and (in less marked degree) upper eyelid and mid-temple; backwards, to the anterior edge of the ear; and below, to about the lower edge of the ramus of the jaw. Beyond these limits—*i. e.*, over forehead, scalp, ear, back and side of neck, sensibility is normal. The right conjunctiva also is normally sensitive.

In the right half of the cavity of the mouth, common sensibility, and in the corresponding half of the tongue, both it and the sense of taste, are almost wholly lost. During meals, from his not feeling the food between the tongue and the right cheek, a little food and drink often escape out of that corner of the mouth. Sight and hearing on the right side are unimpaired. It is doubtful whether the sense of smell is as acute in the right nostril as in the left. Speech and deglutition are normal. He has full control over all the facial muscles, and perfect symmetry exists between the two sides of the face, whether its muscles are still or in action.

He is a strongly-built, healthy-looking labouring man, and declares he never had a day's illness in his life. No trace or history of gout, rheumatism, or syphilis; no dropsy; no albumen in urine. He owns, however, to very slight habitual cough, and (for an uncertain time past) to some little shortness of breath on unusual exertion. Auscultation reveals considerable hypertrophy of heart, with disease both of aortic and mitral valves; and it is conjectured that embolism may very possibly account for the loss of function which has occurred in certain sensory ganglia.—*Med. Times and Gazette*, March 4th, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Bursæ in front of the Wrist and Palm of the Hand.—Dr. Frank H. Hamilton, in some remarks on this affection (*Med. Record*, March 1, 1871), thus speaks of it treatment. A variety of plans have been suggested and practised with more or less success by surgeons, including incision, excision, injections of iodine, acupuncture, blisters, etc. I am persuaded, however, from my own experience, that no surgical interference is ever proper, except it be to open the sac freely,

whenever suppuration is imminent or has already taken place. Velpeau relates that in 1822 he saw Prof. Richerand, at the Hôpital St. Louis, open a similar tumour in a girl nineteen years old, of a strong constitution. The operation was performed with every necessary precaution, but intolerable pain and violent inflammation ensued, resulting in abscesses, and she was not out of danger until after six weeks of suffering. He adds that he has seen the operation of incision, or of passing a seton through, followed by death in several instances at Hôtel-Dieu. I have seen a patient succumb to spontaneous inflammation and suppuration of the bursæ; and Mr. Tatum, in Holmes's Surgery, has reported a similar example. Pressure is in some cases serviceable, but generally it will be best to leave the case entirely to Nature, only taking care that it shall not be subjected to injury.

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A Speedy Method of Artificial Respiration in Asphyxia.—Dr. Harvey L. Byrd recommends (*Baltimore Medical Journal*, November, 1870) the following method for performing artificial respiration in the new-born: Bring the *ulnar side* of the hands together, with the palmar surfaces looking vertically, then prop them beneath the back of the infant, so that the extended thumbs may aid, as far as possible, in sustaining the vertex and inferior extremities. Then keeping the *ulnar* borders of the hands in contact, so as to form a fulcrum, the radial borders or sides are simultaneously depressed to as great an extent as practicable, say forty-five degrees *below* the horizontal line, and then gradually elevated or promoted to as many degrees *above* that line, thus facilitating the escape of air drawn into the lungs during the downward movement of the head and chest. These movements, performed in a regular and gentle manner, and repeated at proper intervals, seldom fail in the establishment of respiration when it is possible of accomplishment. A little cold water dashed upon the epigastrium during the *descent* of the head and chest, will hasten respiration when the first few movements fail in its establishment. It is important that the head be kept, as far as practicable, in the antero-posterior axis with the vertebral column during the process.

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Bond's Placental Forceps.—A correspondent of the *Medical Press and Circular* writes (No. for Feb. 22d, 1871) to inquire whether these forceps can be procured in Dublin? to which the editor replies, they are not known to the leading London and Dublin houses.

A description of these forceps, with a figure, was published in the No. of the *American Journal of the Medical Sciences* for April, 1844, and they are noticed in Prof. Hodge's *Principles and Practice of Obstetrics*, pp. 435, 436, and further an improved form of them is figured in this last work, pl. xv. figs. 85 and 86.

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Medical Graduates in 1871.—The following list shows the number of graduates in several of the medical schools in this country:—

University of Pennsylvania, 114.
Jefferson Medical College, 127.
Harvard University, 45.
College of Physicians and Surgeons, New York, 85.
Bellevue Hospital Medical College, 134.
University of New York, 90.
Medical College of Ohio, 50.
Miami Medical College, 48.
Cincinnati College of Medicine, 17.
Rush Medical College (Chicago), 83.
Indiana Medical College, 32.
Iowa Medical College, 32.
University of Nashville, 66.

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University of Pennsylvania; Auxiliary Faculty of Medicine.—The Board of Trustees of this University have recently determined to confer the degree of Doctor of Philosophy (Ph. D.) upon "Graduates in Medicine of the University (or of schools recognized by it), who shall also have attended two courses of the Auxiliary Faculty of Medicine, and passed a successful examination by this Faculty."

Such a candidate for the honour must, in addition to his knowledge of all the usual branches of medicine, be acquainted with at least *five* branches of especially *Scientific* learning, viz., *Chemistry*, includ-

ing *Physics* and *Botany*, *Comparative Anatomy*, *Zoology*, *Geology*, and *Mineralogy*.

The University does not intend conferring this degree as a mere honorary one, but requires that the candidate shall pass an examination for it.

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University of Pennsylvania.—Professor Henry H. Smith has resigned the Professorship of Surgery, which he has held for the last sixteen years, in this Institution.

The members of the Graduating Class in recognition of his services and as a mark of personal esteem, on Commencement Day (March 14, 1871) presented Prof. Smith's portrait to the Trustees of the University, with the request that it be hung in the Wistar and Horner Museum with those of the professors who in past time were honoured with the same compliment.

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American Medical Association.—The Twenty-second Annual Meeting of this Association will be held at San Francisco, California, commencing at 11 o'clock on Tuesday morning, May 2d, 1871.

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Alumni Association of the Medical Department of the University of the City of New York.—The Executive Committee of this Association purpose the publication, at the earliest possible date, of a complete catalogue of the graduates from that institution since its foundation. As the records of the Faculty were destroyed in the burning of the college building some years ago, it is earnestly requested that each alumnus will, without delay, forward for enrolment his full name and post-office address, with his professional history, including date of graduation, posts of honour and trust held, etc., and also any information which he may possess concerning former classmates who have since died or retired from practice. Communications should be addressed to the Secretary, Charles Inslee Pardee, M. D., 72 West 35th Street, New York.

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American Journal of Pharmacy, published under the authority of the Philadelphia College of Pharmacy.—This valuable journal, devoted to the advancement of pharmaceutical knowledge, has since the first of the present year been changed from a bi-monthly to a monthy, and we are pleased to see that its able and experienced editor, Mr. William Procter, Jr., continues at his post.

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Transactions of the Medical Society of the State of New York.—Of the early volumes of these transactions but a few copies were published, and since the importance of the proceedings of the Society became better known, a demand sprang up for those volumes which could not be supplied. A limited number of the proceedings for the years 1840, '41, '42, and '43 have recently been reprinted, so that an opportunity is now afforded to those who desire to complete their sets of these valuable Transactions.

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Bellevue Hospital.—Dr W. T. Lusk has been appointed one of the physicians to this hospital, in the place of the late Dr. Geo. T. Elliot.

FOREIGN INTELLIGENCE.

On the Therapeutic Value of Iodine in the treatment of Syphilis.—The preparations of iodine, in the opinion of Mr. James R. Lane, of the Female Lock Hospital (*Lancet*, February 25, 1871), have no therapeutic value whatever in primary syphilitic ulcerations, whether attended with induration or not. He believes them to be equally useless in the class of symptoms usually termed "secondary," at all events in their earlier stages, when mercury, under proper management, has so eminently beneficial an effect.

The preparations of iodine have their special application in the treatment of the class of symptoms usually denominated "tertiary." These are skin affections tending to ulcerate—such as tubercle and rupia, destructive ulcerations of the throat and palate, affections of the periosteum and bones, gummatous tumours of the cellular and muscular tissues, and affections of similar character in internal organs; some forms of orchitis and also of

iritis might be included in the list. In Mr. Lane's opinion, nothing is more certain than that, as a rule, mercury is injurious in this class of affections; they show themselves at a period when the direct influence of the syphilitic poison appears to have passed away, and to have left behind it a cachexia, which manifests itself in the destructive conditions above enumerated. These are essentially asthenic in their origin, and the remedies required are those which will repair the failure of nutrition and restore the debilitated powers. Good diet and stimulants, with pure air and other favourable hygienic influences, are essential; but, in addition to these, we have in the salts of iodine a remedy the value of which it is impossible to exaggerate. Amongst them the iodide of potassium holds deservedly the highest repute. Under its influence, rupial ulcerations heal in the most remarkable manner, periosteal swellings disappear, the gummatous tumours known as soft nodes are rapidly absorbed, and the strength and weight of the patient are increased. It is true that he is not at once permanently cured; it is not to be expected that so serious a diathesis can be changed in a few weeks, although its outward manifestations have been removed and destructive action has been arrested. The symptoms will return again and again, and the remedy must be again and again resorted to, with the result, in the great majority of cases, of a cessation of all outward symptoms and the ultimate permanent restoration to health of the patient. It is a mistake to suppose that a recurrence of symptoms is an indication of the failure of the remedy; it is, on the contrary, a reason for its repetition; and even the appearance of fresh symptoms during its use should be regarded as an additional motive to persevere and to augment the quantity given.

The iodide of potassium should be commenced in doses of three grains, to be gradually increased to fifteen or twenty grains, thrice daily. It agrees best, and its efficiency is increased, when combined with carbonate of ammonia, and administered in a diluted condition. The decoction of sarsaparilla is an excellent vehicle, and is in itself useful as a tonic. The iodides of sodium and ammonium are inferior, in Mr. Lane's opinion, to the iodide of potassium; but when the latter disagrees, and produces dryness of the throat, headache, and coryza, they may be substituted for it with advantage, as they are certainly not so liable to be attended with these unpleasant effects. Mr. Lane has not met with a case in which one or other of the iodides could not be borne, if the dose at the commencement was sufficiently reduced—and in some cases it has been found necessary to make it as small as half a grain—when given carefully, and by slow degrees, toleration will be established. In all cases the gradual increase of dose is a point of great practical importance. It is by persisting in the same dose that the good effect is often missed, that disappointment ensues, and the remedy is discredited.

Mr. Lane has rarely found the iodides of any service in purely secondary affections. He believes that, on the contrary, they will almost always be found injurious in the early stages. From their stimulating properties they tend to aggravate skin affections, and especially to irritate disordered mucous membranes. If from any cause it is thought advisable to abstain from mercury in the early secondary stage, it is a mistake to suppose that the next best thing is to give the iodide of potassium.

From what has been said, it may be inferred that Mr. Lane is not in favour of the combination of mercury with the iodides in the treatment of syphilis, although the practice is frequently adopted. A very favourite method is to give the perchloride of mercury in combination with the iodide of potassium in secondary affections. The result is, of course, a solution of biniodide of mercury with iodide of potassium in excess. This appears to be "blowing hot and cold" at the same time, since the one remedy tends to neutralize the effect of the other; and, in most cases, where the one is necessary the other is injurious.

If there are any cases in which such a combination is desirable, it would appear to be those which are passing through

the transition period between the secondary and tertiary stages, when the symptoms partake somewhat of the character of both periods—when, for instance, there are patches of scaly or papular eruption coincidently with disease of periosteum and bone, with recurrent iritis, chronic enlargement of the testis, or gummatous swellings.

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Internal Œsophagotomy in Cicatricial Contractions of the Œsophagus.—M. Trélat describes (*Bulletin de l'Académie de Médecine*, t. xxxv. p. 241) a case of stricture of the œsophagus, resulting from the action of a corrosive liquid that had been swallowed, and in which the mode of treatment by gradual dilatation had long been employed in vain. The stricture was immediately above the cardia, and he at length determined to employ an instrument he had previously invented and delineated, and which consisted of a slightly curved shaft, about twenty inches in length, which towards its lower extremity presented a dilatation flattened on one side. Below this were two cutting blades that could be made to protrude to the desired extent by means of a screw. The instrument was forced through the stricture, the concealed blades thrust forth, and the instrument was then withdrawn.—*The Practitioner*, December, 1870.

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The Treatment of Orchitis.—M. Besnier (*Bull. de Thérap.*, 1870) has found a simple method of treatment so successful in orchitis of all kinds that he thinks it proper at once to submit it to the consideration of the profession.

The patient is kept at rest, the scrotum is raised, and compresses steeped in a concentrated decoction of the leaves of digitalis are kept constantly applied. The compresses applied may be either lukewarm or cold, and are taken off when they begin to dry. The application must be kept on incessantly. With some folds of cloth under the pelvis and some waterproof around the wet compresses, the application can be carried on with little inconvenience to the patient.—*Dobell's Report on Progress of Medicine*, 1870.

Incontinence of Urine successfully treated by the Syrup of the Iodide of Iron.—Dr. John Barclay, of Aberdeen, states (*Med. Times and Gazette*, Dec. 17, 1870) that, during the past two years and a half, twenty cases of incontinence of urine have been treated by him with the syrup of iodide of iron alone; and, so far as he knows, without a single failure. He gives the details of eleven of these cases. He gave the medicine in doses of from 15 to 30 minims three times a day.

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Nitric Acid in Bright's Disease.—Dr. Máy Figueira, Physician to the Royal Hospital of St. Joseph, at Lisbon, has found great benefit from the use of pure nitric acid mixed with water (as lemonade) in Bright's disease. He has found it inferior to tannin, borax, tincture of cantharides, perchloride of iron, etc. He gradually increases the dose to twenty-four and thirty drops four times a day. Milk and raw onions he found most useful in diminishing anasarca and albuminuria.—*Dobell's Report on Progress of Medicine*, 1870.

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Chloral Hydrate in Puerperal Mania and Puerperal Convulsions.—Dr. Phillips stated to the Obstetrical Society of London that during the past nine months he had used the hydrate of chloral extensively in the puerperal state, especially in five cases of puerperal mania, and two of puerperal convulsions. In four of the five cases of mania its action had been very beneficial, while in the fifth it failed to produce sleep, though given in full doses. In one case of mania the patient had no sleep for three days, though opium had been given, but within five minutes of taking half a drachm of hydrate of chloral she fell asleep for four hours, and again for five hours more. In another case, on the fourth day it was given in full doses, and the next day the patient was quite rational. The chloral hydrate was very suitable in the restless, sleepless condition not uncommon after delivery. A drachm dose produced no effect in one case of convulsions, while in another, in which the paroxysms were severe and frequently repeated, the action of the

chloral was very marked. It was very satisfactory to receive such a favourable account of chloroform in obstetric practice from one so accustomed to its use as Dr. Kidd was. He (Dr. Phillips) had seen it used extensively in abnormal labours without untoward effects, and this notwithstanding that he had had it used continuously for twelve consecutive hours in puerperal convulsions.—*Med. Times and Gazette*, February 4, 1871.

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Value of the Preparations of Conium.—Dr. John Harley in an article on this subject in *The Practitioner* (Dec. 1870), states that the advantage of the *green fruit* over every other part of the plant is so clear and decided, that nothing need be said in favour of its selection as the basis of the tincture and extract. The extract of the Pharmacopœia is a scandal to the present state of medical knowledge, and a spirituous extract of the green fruit ought as soon as possible to take its place; then indeed we shall have an extract of which the proper dose will be "from 2 to 6 grains," instead of from 20 to 60 grains or more, which is the efficient dose of the present extract.

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Kali-Kutki—A New Tonic.—Mr. M. C. Cooke, in a late number of the *Pharmaceutical Journal*, gives a description and an account of the properties of this plant, which has long been considered to be the black hellebore, but which really belongs, not to the Ranunculaceæ, but to the Serophulariaceæ. Though unknown in the English market, it is well known throughout India. The drug consists partly of the root and partly of the stem of the plant. The root part is very light and brittle, about the size of a goose-quill, brownish-white in colour externally, and deep black internally, with short, waxy fracture. It is stated to be a very valuable tonic, Assistant Surgeon Mourdeen Sheriff considering it equal to gentian and calumba, and superior to chirayta. As a dose, ten or twenty grains as a tonic, and from twenty to forty as an antiperiodic, are recommended.—*Lancet*, Feb. 4, 1871.

Malt Extract.—Mr. Ebert, in the *Pharmacist*, draws attention to the fact that ordinary malt extract is simply good porter sold at an exorbitant price, and gives the following process as one really calculated to produce a valuable article: Take of barley malt, kiln dried, 10 lbs. av., Water q.s.

The malt is reduced by the drug mill so that it will pass through a No. 20 sieve; and to the meal is added a sufficient quantity of cold water to form with it a soft dough. Two gallons of hot water are then added, and heat applied until the temperature is raised to 150°, or not to exceed 158°. This temperature is maintained with occasional stirring for several hours, until the whole of the starch is converted into dextrine and glucose by the diastase of the malt. The absence of the starch can be ascertained by the application of a solution of iodine. When the whole of the starch has gone there is no more blue colouration with iodine. The liquor is to be expressed rapidly and passed through a strainer. This it would seem is a difficulty, as it speedily clogs up the strainer. Mr. Ebert suggests, however, an ingenious mode of remedy, which is, of course, applicable to many processes. It is to make a pulp of unsized or filtering paper, and mixing this pulp with the expressed fluid previous to straining. The perfectly clear liquor is to be evaporated by means of a water-bath to the consistency of a thick syrup, having the sp. gravity 1.500, or approximately one pint, and weighing one and a half pound.

The extract has an agreeable syrup taste, and contains, besides the sugar of the malt, dextrine, albumen, and the phosphates of the grain. In very hot summer weather, says Mr. Ebert, it is liable to fermentation, but this can be prevented by the addition of a small quanty of glycerine.—*Med. Press and Circular*, Feb. 22, 1871.

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Death from Chloroform.—Dr. Blodz reports (*Wiener Med. Woch.*, Dec. 31, 1870) a case of this which occurred at the Eye Infirmary at Gratz. About two drachms of chloroform were administered to a lad

aged 11, and an iridectomy performed. During the dressing, and six or eight minutes after the completion of the operation, the lad was observed to make several rapid respirations and then cease to breathe. The autopsy failed to exhibit any peculiarity.—*Med. Times and Gazette*, Feb. 25, 1871.

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Tooth-Plate and Teeth Swallowed.—Mr. Henry Smith showed to the Medical Society of London a gold tooth-plate and teeth that had been swallowed by a gentleman, a patient of Dr. Hamilton, of Mitcham. Mr. Smith saw him six hours after the accident, and was able then to touch the plate with a pair of long forceps; but all attempts at extraction were unavailing. Mr. Smith therefore pushed the plate down into the stomach. The patient felt relief; and nine days afterward passed the plate by the bowel, with but little pain. Mr. Smith also showed a similar plate in vulcanite, given him by Dr. E. Johnson, that had been swallowed, and passed through the patient in safety. Dr. King narrated the case of a man in the Edinburgh Infirmary who had swallowed his false teeth. Mr. Syme, not being able to pull the teeth up, at once pushed them down. A few days afterwards, Dr. King was sent for to see the man, and found him dead. The angular hooks on the tooth-plate had torn the œsophagus and perforated the aorta. In the stomach was a complete cast of its cavity in blood-clot. Mr. Carter had seen a case where a brooch was swallowed. The patient was made to eat a large quantity of bread, and then an emetic was given, when the bread and brooch all returned together. Dr. Morell Mackenzie was in the habit of using in such cases an instrument known on the continent as the *ramoneur*. It was passed down, and, as it was withdrawn, a sort of brush, expanding, caught the foreign body, and so removed it.—*British Med. Journal*, Feb. 4, 1871.

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Morbid Anatomy of Tetanus.—Dr. Allbutt exhibited to the Pathological Society of London some microscopical specimens of spinal cord, illustrative of the morbid anatomy of tetanus. They were taken from four cases, all traumatic. The first patient suffered from laceration of the skin and injury to the ankle. The cord was soft in many parts, especially in the upper portion of its course. The posterior tibial nerve was removed, and its sheath found full of pus. The second was a girl, who lacerated her finger. The nerve of the forearm was not examined. The third patient had been operated on by Chopart's method. The cord was soft in the dorsal region, and a clot was found in the lumbar enlargement. The sheath of the posterior tibial was full of pus. The fourth case was one of compound fracture of the leg. The cord was soft chiefly in the dorsal region, and there were some hemorrhages throughout. Dr. Allbutt said that in all the cords changes were observed, especially softening. In two there were hemorrhages, the blood-vessels were distended, thickened, varicose, and plugged, and there were spaces round these vessels, either full or empty. There was also proliferation of epithelium in the central canal, which was stuffed with it. There were changes in the connective tissue of the cord, and washing out of cells in the anterior cornua, where also small yellow lumps were to be seen, as of motor cells degenerated.

Dr. Dickinson had found the same condition of bloodvessels. The thrombosis was difficult to make out after soaking in chromic acid.

Dr. Moxon had never seen anything like inflammation; the vessels were often full, but there was never anything like thrombosis in the specimens he had seen. The cord was often anæmic. There was no thickening of the membranes or anything like lymph in those he had examined, but he had seen epithelium proliferated in the central canal. He thought the tetanic condition due to irritation, not to any distinct change, as in the cases which recovered no paralysis was left, and death resulted from over-action, not from impaired action.—*Med. Times and Gazette*, February 18th, 1871.

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A Woman with Four Breasts.—A primiparous woman was admitted under M. Lorain, and was delivered the next day of

a dead premature child. She was found to have four breasts, two in the normal position and with the normal puerperal appearances, and two which, from their position, might be called axillary, and attaining the size of a small orange. She menstruated at twelve, and at the periods she experienced pain in the small breasts. The colostrum also which these contained was small in quantity, and the granular bodies were less and transparent, while the milk-globules were fewer. The areolæ was also very small. In spite of an attack of fever, the lacteal secretion was regularly established in all the breasts, but the milk examined microscopically was found of a much poorer quality in the supplementary breasts.—*Med. Press and Circular*, Jan. 4, 1871, from *Revue Photographique des Hôpitaux.*

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Smallpox in London.—The mortality from this disease for the weeks ending February 4, 11, 18, and 25, has been respectively, 196, 211, 218, 227. That the present epidemic is more severe than any during the last 30 years is shown by the fact that the average mortality for the past nine weeks has been 168½, while in an equal number of weeks during the previous most severe epidemic (1840–41) the weekly average was only 71. In Liverpool the epidemic is more severe; the annual death-rate from smallpox for the last week in February was equal to 3.6 per 1000 in London, while it was 12.9 in Liverpool. Smallpox has spread in an unusual degree over the whole of Europe.

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Stage at which Smallpox is contagious.—There are some who, perhaps arguing from analogy, are disposed to think that a communicable virus is not given off until the specific eruption appears upon the skin, and some who regard the disease as scarcely likely to be communicated even during the first day or two of the eruptive stage. We are sure that this notion is as inconsistent with facts as it is dangerous to the public health. The observations of highly competent men have satisfied us that the cutaneous eruption is no proper criterion to go by, and that smallpox may be communicated when not a single pock has appeared upon the skin. It was only a fortnight ago that a case of petechial typhus, fatal in a few days, was reported to one of the metropolitan health officers. Suspecting that there might have been an error in the diagnosis, he saw the surgeon who reported it, and learned from him that the illness commenced with severe pain in the back and other initiatory symptoms of smallpox; and, moreover, that the patient, a girl, had been exposed to smallpox contagion. In this case there was no eruption up to the death, yet a sister who lived in the house and assisted in nursing her was about a fortnight after the death attacked with smallpox. That a variolous fever without eruption prevailed in epidemic seasons was an old observation of Sydenham. That people with this form of the disease, ignorant of its nature, may go about and communicate smallpox, is not an improbable way of accounting for some of those attacks in which no direct or indirect exposure to contagion can be traced. However this may be, it is obviously a prudent course to interdict personal intercourse with individuals who, during the prevalence of the epidemic, show the symptoms of the initiatory fever, whether they issue in eruptive smallpox or subside without the development of pocks.—*Med. Times and Gazette*, February 25, 1871.

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Diphtheria in Germany.—It is stated in the *Med Cent. Zeit.*, that this complaint is prevailing extensively in Berlin, attacking both old and young. It also is prevalent in the military hospitals.

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The International Congress of 1871, *in Vienna.*—This will be the third of the series, the second having been held at Florence, in 1869. The committee had been appointed in the latter city, and has now chosen its officers. President: Prof. Rokitansky. Vice Presidents: Profs. Duchek and Sigmund. Secretaries: Drs. Benedikt and Schnitzler. The committee will request the assistance of the medical corporations of Vienna, and at once begin the work of organization.

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We wish for once that our province was not restricted to methods of treatment, that we might say something of the exquisite colored plates in this volume.—*London Practitioner*, May, 1869.

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Other writers beside M. Cullerier have given us a good account of the diseases of which he treats, but no one has furnished us with such a complete series of illustrations of the venereal diseases. There is, however, an additional interest and value possessed by the volume before us; for it is an American reprint and translation of M. Cullerier's work, with incidental remarks by one of the most eminent American syphilographers, Mr. Bumstead. The letter-press is chiefly M. Cullerier's, but every here and there a few lines or sentences are introduced by Mr. Bumstead; and, as M. Cullerier is a unicist, while Mr. Bumstead is a dualist, this method of treating the subject adds very much to its interest. By this means a liveliness is imparted to the volume which many other treatises sorely lack. It is like reading the report of a conversation or debate; for Mr. Bumstead often finds occasion to question M. Cullerier's statements or inferences, and this he does in a short and forcible way which helps to keep up the attention, and to make the book a very readable one.—*Brit. and For. Med.-Chir. Review*, July, 1869.

It was with unmingled satisfaction that we heard the announcement that the French surgeon's magnificent treatise was to be reproduced in this city, in a style which would be in every respect worthy of the original, and yet which would be offered at such a price as to be readily attainable by every surgeon throughout the whole extent of the United States. The first portions of this splendid book have already formed the subjects of short bibliographical notices in the numbers of this Journal for April and July, 1868. But now that it is complete, and stands before the profession in its goodly proportions as a whole, it becomes our duty to offer our readers a more elaborate and a more critical review of its many and great excellences. The 76 plates of the original are here accurately reproduced on 26 plates containing 145 figures. These we have very carefully examined, and have no hesitation in pronouncing them to be the best illustrations of any medical work in our language with which we are acquainted. The most splendidly illustrated work in the language, and in our opinion far more useful than its French original. It is besides furnished at little more than one-half the price of the French edition, and must, we think, remain for a long time the most desirable book on venereal diseases attainable by the American practitioner.—*Am. Journal of Med. Sciences*, Jan. 1869.

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GUERSANT ON SURGICAL DISEASES OF INFANTS, ETC., 16 PAGES.

CLINICS.

CLINICAL LECTURES.

Clinical Lecture on the Treatment of Hæmoptysis. By A. T. H. WATERS, M.D., Physician to the Liverpool Northern Hospital.

GENTLEMEN: I wish to call your attention to the treatment of hæmoptysis. Cases of this affection are very frequently met with in our wards, and will often occur to you in your practice hereafter. There is scarcely any symptom which more alarms the patient, or a patient's friends, than the expectoration of blood; for people have a well-founded belief that it is a very common indication of the existence of pulmonary consumption. Indeed, setting aside those cases in which hæmoptysis is associated with heart-disease, or is of a vicarious character, in a very large proportion of the remainder it is undoubtedly connected with phthisis. I do not mean to say that hæmoptysis always indicates the presence of tubercles in the lungs, for I believe it may occur at a very early period of consumption, and before any tuberculous deposit has taken place—in fact, that, at times, it is the first indication of phthisis, and may determine the development of that disease. The existence of hæmoptysis cannot prove to you that pulmonary consumption has arrived at any particular stage; for just as, I believe, it may take place before there is any tuberculous deposit, so it may occur when the disease is far advanced, and the lung full of cavities.

Considering the frequency of hæmoptysis, it is only in a small proportion of cases that it proves fatal—the patient dying suddenly from the profuseness o

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the hemorrhage, and consequent suffocation, or sinking more or less rapidly from exhaustion. A case of rapid sinking occurred not long ago in my practice in the hospital, and I will briefly relate it to you.

H. G., aged 30, was admitted under my care on October 12th, 1869. He was brought from a vessel which had just arrived in the port, and was spitting up large quantities of blood. He was in a sinking state when admitted, and he died in about six hours. He had been under my care in the hospital three months previously. At that time there was dulness, with other signs of consolidation at the base of the left lung, and I considered the case to be either chronic pneumonia, likely to develop into phthisis, or phthisis beginning at the base. On making a *post-mortem* examination, we found a large cavity at the base of the left lung, and a smaller one at the apex, and the substance of the lung was studded throughout with tubercles. The anterior part of the lung was emphysematous, and also contained tubercles. The right lung was more or less emphysematous throughout, and infiltrated with tubercles. In the middle lobe there was a large cavity filled with blood. A considerable quantity of blood was also found in the stomach. Here, then, we had a case in which ulceration or rupture of a large vessel on the walls of a cavity produced hemorrhage so profuse as to cause rapid death.

This is the only case that has occurred in my practice in this hospital where hæmoptysis has been *directly* fatal; but, curiously enough, within a short time—about ten days—of the death of my patient, my colleague, Dr. Glynn, lost a patient from pulmonary hemorrhage, and, after death, a cavity was found in the left lung, into which blood had been poured in large quantity.

Whenever hæmoptysis is only slight, during the progress of a case of phthisis, no special treatment need be directed to it. It is better to continue the measures which you are adopting for the general treatment of the disease, and give encouragement to your patient if he be disposed to be alarmed at the appearance of a few specks of blood. But should the hemorrhage be at all severe, you should at once enjoin rest, nor should you allow your patient to take exercise, or run any risk, by which an inflammatory attack might be brought on, until all appearances of blood have been lost for some days. I consider this rest and care most important, whether there have been no previous symptoms of phthisis and no other signs are present, or whether you have indications of existing deposit; and for this reason: that hæmoptysis is not unfrequently followed by pneumonia, especially where the hemorrhage has been severe. When blood is poured out into the lungs, unless it be all expectorated, it must necessarily act as an irritant, and inflammation is liable to set up around it. This inflammation is often of a limited character; but, in two instances which have occurred to me within a somewhat recent period, extensive pneumonia followed hæmoptysis. It is true that in both these cases the hemorrhage was copious, and in one which I shall relate to you a very large quantity of blood was lost.

I would caution you, therefore, to be on your guard, in all cases where hæmoptysis is at all severe, against the occurrence of pneumonia. It is better, I think, to err on the side of keeping the patient quiet, than to allow him to incur risk by too early exercise or exposure. The pneumonia which may result from pulmonary hemorrhage may determine the development of phthisis, which might possibly, by the exercise of proper care, have been prevented from becoming developed.

There is a kind of hæmoptysis which I have met with which is, I believe, the result of a simple oozing of blood from the mucous membrane of the bronchial tubes. The blood is not mixed with viscid sputa, nor is it pure blood; but the expectoration has very much the appearance of currant-juice. I have lately had a patient in whom this kind of expectoration had existed for a considerable time, and in whom, at the time he first came to me, I could discover no physical signs of consolidation of either lung. He had taken various medicines for the hemorrhage, but nothing had done much good. I did not for some time adopt any special treatment for the

bleeding, but confined myself to the administration of tonics, quinia, iron, and cod-liver oil. But, finding that the symptom did not cease, I ordered gallic acid in ten-grain doses three times a day. This had the desired effect, and soon the hemorrhage stopped. It has recurred at intervals, but the patient is able to check it by resorting to the gallic acid. Since I first saw the case, twelve months ago, symptoms of deposit in the right lung have supervened.

I will now call your attention to one of the most severe cases of hæmoptysis which I have ever seen. It will serve to illustrate the principles of practice which should be adopted in the treatment of this affection.

H. B., a German, 28 years of age, described as a merchant, was admitted into the hospital under my care on the 18th September, 1868. He had just come by sea from Hamburg, and had suffered much from sea-sickness in consequence of rough weather. He told us that a year previously he had expectorated some blood, and that subsequently his health had been pretty good. I saw him soon after his admission. He was coughing up blood of a bright red colour, and in considerable quantities. His pulse was quiet, but he appeared very weak. I ordered him three grains of acetate of lead, with half a grain of opium, every four hours. I directed that he should be kept perfectly quiet, and have nothing in the way of food but small quantities of iced milk or beef-tea. I saw him on the evening of the following day. He had passed a bad night; the hemorrhage had been very profuse; the blood was almost pure, and, although I did not measure it, I am sure that many ounces had been brought up. It was kept in several vessels, and one might have thought that a series of small venesections had been practised. The pulse was 90, and the patient had taken his food pretty well. I ordered the pills to be given every two hours, and ice to be applied to the chest. On the 20th the quantity of blood expectorated was about the same as before, but the pulse had risen to 100. The patient was getting drowsy, and the pupils were contracted. I therefore stopped the opium, but continued the acetate of lead, and ordered dry cupping between the shoulders. I carefully examined the chest, but could find no marked physical signs of phthisis. There was, however, slight dulness, with deficient movement at the right apex. The heart sounds were normal. On the following day there was a slight decrease in the hemorrhage, but still the blood was in large quantities, quite fluid and florid; the narcotism had passed off, and the pulse had fallen a little. I consider that there was a *slight* improvement in the patient, but that the remedies were not acting quite satisfactorily, and that, unless the hemorrhage were soon checked, the patient would sink from exhaustion. I had given a fair trial to the acetate of lead. It had been taken for three days in frequent doses with very little effect, and I felt that some other measures should be used. I therefore ordered ten grains of gallic acid every two hours; the ice to be continued to the chest, and as much nourishment, in the shape of milk, beef-tea, and eggs, to be given as could be borne. The effect of the acid was very marked. On the 22d, when I saw the patient, after he had taken the acid for twenty-four hours, he was spitting up only little masses of blood, and the quantity was largely diminished. On the following day the improvement was still more marked, and I ordered the mixture to be taken every three hours only. On the 24th, the hemorrhage was very slight, and the pulse had fallen to 84. The gallic acid was now ordered to be taken every four hours; and on the 27th he was perfectly free from hæmoptysis, and, in fact, convalescent from his attack. But now mark what followed. On the 29th he began to get worse; the pulse rose; he became feverish; and, in fact, an attack of pneumonia of the base of the left lung set in. As I propose to refer in a special lecture to this attack of the patient, I shall say no more than that he made a good recovery from it, and was discharged from the hospital on the 23d October.

There was a very interesting case of hæmoptysis in the wards a short time ago, to which I should like to call attention.

D. C. was admitted into the hospital on the 31st January, 1870. He was 35 years of age, a cab-driver, and consequently had been much exposed to the weather; moreover, he confessed to being a free spirit-drinker. He had been in the habit, for some years, of taking five or six glasses of spirits a day. He told us that he had suffered from a cough for about two months, but that up to three days before his admission he had brought up nothing but phlegm. On the evening of January 28th he coughed up, he said, about half a pint of blood; on the following day, about a pint; and, again, on the 30th, about a pint. I saw him soon after he came to the hospital. The hemorrhage had ceased, the respiration was not hurried, and the pulse was quiet. I did not examine the chest carefully, as I did not wish to disturb him for fear of reproducing the hæmoptysis; but, from the slight examination I made, I could detect no organic disease. The man had a large pupil, a somewhat strumous aspect, and there was a flush on each cheek. The urine, on examination, was found healthy. I ordered acetate of lead and opium, and ice to the chest. For two or three days after his admission, he spat blood in small quantities; and on the 5th and 6th of February there was no hemorrhage at all; but on the 8th it returned somewhat profusely. I at once ordered him ten grains of gallic acid every four hours, and, as the hemorrhage had not quite ceased on the 10th, the medicine was given every three hours. A careful examination of the chest on that day revealed no signs of organic disease. There was good resonance on both sides, and the expansion was good. The heart sounds were normal.

For three days the man was free from hæmoptysis, and I reduced the quantity of gallic acid; but on the night of the 13th February, after reading aloud, he spat up about half a cupful of pure blood. Early on the morning of the 16th he awoke and coughed up about six ounces of blood. He continued to spit up small quantities of blood till the 19th, when there was no hæmoptysis, and the mixture was stopped, but on the following day the hemorrhage recurred to the extent of about half an ounce, and for several mornings he brought up about the same quantity. On the 24th, about 11.20 A. M., he spat up about six ounces of bright arterial blood. The gallic acid was then resumed every two hours, and ice was applied to the chest. The pulse, which had been quiet, became more frequent, 108, but it soon fell. The hemorrhage continued to a slight extent till the 27th, when it ceased, but it recurred on the 4th of March to the extent of a cupful of blood. I then added twenty minims of tincture of ergot to each dose of the gallic acid. From this time the hemorrhage gradually became less and less, and at last ceased. On the 17th he was put on tincture of iron. He had already taken cod-liver oil for about a fortnight. There was no more hemorrhage until the 30th March, on which day he brought up a little blood. I again ordered the gallic acid, and the bleeding was soon stopped. He left the hospital on the 7th April.

I made a careful examination of the chest on several occasions, and once just before the patient was discharged, but I could find no evidence of deposit in either lung, and if any existed it must have been deep-seated.

And now I will call your attention to the various measures which are usually resorted to in the treatment of hæmoptysis. In the first place, I believe that the best remedy you can use, the safest, the most rapid, and the most effectual, is gallic acid. It must be given in full doses—not less than ten grains every hour, or every two, three, or four hours; according to the severity of the case. It is readily taken by patients; it rarely disagrees with the stomach, and is well borne by delicate persons. I have now used it in a large number of cases, and I can speak with confidence of its value. I have rarely found it fail, but still it has not been invariably successful in rapidly checking the hemorrhage. You may recollect the case of Peter R——, who was so long in the house, and in whom hæmoptysis recurred over and over again. I prescribed

a variety of remedies for this man, and each in its turn failed to arrest the bleeding. It is quite true, however, that gallic acid answered better than any other agent used; it never failed to diminish the quantity of blood expectorated, and on several occasions it stopped the hæmoptysis altogether for a time, and this is more than I can say of either of the other substances used. I do not think you gain anything by giving the acid in larger doses than ten grains; but I know that some physicians give it in twenty-grain doses. It rapidly finds its way into the urine and is excreted.

Acetate of lead is another valuable preparation for arresting hæmoptysis; combined with opium it is often of great service. I usually give it in the form of pill in two- or three-grain doses every two, three, or four hours. I have seen very severe cases yield to this treatment. Some of you may recollect one of our house-surgeons who had a bad attack of hæmoptysis, and for whom I prescribed this substance, and who made a satisfactory recovery.

In the opinion of some physicians, acetate of lead is a more powerful styptic than gallic acid, but in the treatment of the form of hemorrhage which we are now considering I prefer the latter; if, however, in any case this failed, I should resort to the lead preparation. If you give it, it must be in the full doses which I have recommended.

Sulphuric acid is a good remedy in slight cases of hæmoptysis; and it may be combined with other substances, as quinia, iron, etc., which are given for the general treatment of the disease; and, indeed, I have seen cases which have been somewhat severe yield to full doses of this acid. There was a man in the wards some years ago who was spitting a good deal of blood, and for whom the house-surgeon had ordered sulphuric acid in ten-minim doses. I saw the patient for the first time after he had been taking the acid for two or three days, but it had not checked the hemorrhage in the slightest degree. I considered the dose too small, and I increased it to thirty minims. In twenty-four hours the hemorrhage had greatly diminished, and it soon stopped. If you are disposed to try this acid in any severe case, you must give it in full doses; but it is not so easily taken, nor is so well borne by patients, as gallic acid. Moreover, as it must be largely diluted to be taken, it necessitates the swallowing of a good deal of liquid, which is generally to be avoided.

Let me give you a caution in reference to the administration of opium. It is well to bear in mind its tendency to confine the bowels, for in treating persons who are very weak for hæmoptysis, you may find that when you have checked the hemorrhage you have great trouble in getting the bowels opened, and the efforts to move them may reproduce the bleeding. Of course, in any severe case you must do all you can to stop the hemorrhage, and opium, either with gallic acid or acetate of lead, is often, I think, useful. It doubtless possesses some styptic powers, and, moreover, is probably of use in sustaining the patient under the influence of the loss of blood. I advise you, however, not to continue its use longer than is absolutely necessary.

My experience of the use of ergot of rye in pulmonary hemorrhage is not very favourable. I have given the tincture in several cases, but I have not been very satisfied with the results. It may be applicable to some cases, but I do not think that it possesses such valuable properties as gallic acid or acetate of lead.

In severe cases of hæmoptysis, I always apply ice to the chest. We know that a cold substance applied to the skin will produce a reflex contraction of distant bloodvessels; and it has appeared to me that ice applied to the chest has been of service in checking hæmoptysis. I have never seen any injurious results follow its use. The ice should be applied in a bag, and should not be kept on sufficiently long to produce a chill.

You will find digitalis recommended by some writers as a valuable agent for checking hæmoptysis. I have frequently found, in cases to which I have been called in consultation, that this medicine has been given, and I know that many practitioners have great confidence in it. They do not, however, prescribe it alone, but in combi-

nation with other remedies, as sulphuric acid and laudanum, so that it is difficult to say how far the results which have followed have been due to the digitalis itself. As far as my own experience goes—and I have frequently prescribed digitalis—I cannot recommend it as a trustworthy remedy in hæmoptysis. You are probably aware that there are conflicting views in reference to the action of digitalis. On the one hand, it has been considered a cardiac sedative; on the other, a cardiac tonic. If, as is alleged by some, it have the power of causing contraction of the smaller arteries, it ought to be, theoretically, useful in hæmoptysis; but on this point I can only give you the result of my own clinical observations, and, having tried it and found it fail, I have given up its use.

I occasionally prescribe dry cupping in hæmoptysis, especially if it be of an active character; but I never fail to give styptics internally at the same time.

With regard to the administration of purgatives, I must caution you against their indiscriminate use in this affection. When you have to deal with tolerably robust individuals you may safely give purgatives, and they will often be of service; but when the hemorrhage is severe, or the patient in a very exhausted condition, you must be very careful how you further lower him by their administration. It becomes sometimes a very serious question whether the movements necessary for the action of the bowels may not prove injurious by opening a vessel which has recently closed. In some cases the thread on which life appears to hang seems so slight that we dare not allow the slightest movement on the part of the patient, and we are glad that the bowels remain inactive.

Whenever your patients show symptoms of exhaustion during the occurrence of hæmoptysis, you need not hesitate to give small doses of stimulants with food at regular intervals. I do not believe that such treatment in anywise tends to increase the hemorrhage, and it has a beneficial effect in sustaining the patient.

There is one remedy to which I have not referred; viz., turpentine. It is most valuable in hemorrhage from the bowels, but less so, in my opinion, in pulmonary hemorrhage. However, it is an agent to which you may have recourse should other measures fail.

A few words as to the general management of your patient. Let him be kept perfectly quiet, and do not allow any person to be with him except his nurse. Take care that his room is kept cool and well ventilated, and give no other food than milk and beef-tea, in small quantities and iced. Thirst will often be complained of: this is best relieved by small lumps of ice. You must not allow large draughts of iced-water, and everything likely to cause vomiting or distension of the stomach must be specially avoided. Lastly, let me advise you not to disturb your patient for the purpose of making unnecessary physical examinations.—*British Medical Journal*, March 11, 1871.

HOSPITAL NOTES AND GLEANINGS.

Hygroma of the Hyoid Bursa.—W. L., æt. 30, a carman, applied to Dr. Morell-Mackenzie at the Hospital for Diseases of the Throat, on Nov. 25, 1870, on account of difficulty of breathing and swallowing, which he attributed to a swelling just below the chin. He stated that he had first noticed the swelling about seven or eight years ago, but that it had never caused him any trouble till 1867, when he took cold, and the swelling greatly increased in size. He then consulted an eminent surgeon, who advised him to leave it alone. Subsequently, however, it caused him a great deal of inconvenience, and occasionally prevented him doing his work. The swelling had become much larger during the last year.

On examination, an ovoid tumour, about the size of a hen's egg, was found extending horizontally across the neck, and slightly attached to the hyoid membrane. The tumour was mobile, firm, and elastic. There was fluctuation on palpitation. The skin over it was healthy and non-adherent.

The case was diagnosed to be one of hygroma of the hyoid bursa, and Dr. Mackenzie directed that the cyst should be punctured, and a small seton afterwards

be put through. This was done. About three ounces of a transparent, but viscid yellowish-white fluid were drawn off. A few threads were afterwards carried through the cyst. The same evening the patient had a shivering fit, and could not sleep.

On the following morning he experienced much difficulty in swallowing, and some shortness of breath. The surface of the swelling was inflamed, and, on making a laryngoscopic examination, the epiglottis and mucous membrane of the larynx were seen to be in a state of general hyperæmia. An inhalation of the compound tincture of benzoin, and poultices over the neck were ordered.

On the 27th the bursal cyst was found to be tense, and thick laudable pus escaped from the seton openings. Dr. Mackenzie ordered one of the orifices to be slightly enlarged, and the seton removed, when a quantity of pus was poured out. This purulent discharge continued for a few days, and at the end of four weeks (December 26, 1870) the wound had healed, and the man was made an out-patient.

January 14, 1871. Finally discharged cured, there being no remains of the cyst.

Remarks.—Dr. Morell-Makenzie observed that these cases are interesting, both on account of their rarity and of the close connection which the bursa has with the larynx. A valuable communication on this subject was read before the New York Medical Association, by Dr. F. H. Hamilton, in 1869, and reported in the *Medical Record* of February, 1870. Several cases were reported by him under the name of "superlaryngeal encysted tumours," or "encysted bursal tumours in front of the larynx." On that occasion, Dr. Elsberg gave an interesting historical *résumé* of the subject. On account of their close connection with the larynx, any curative treatment of these tumours is likely to give rise to laryngitis. The plan commonly adopted consists in puncturing and injecting iodine; but this treatment is not so certain as that by seton, for the cyst not unfrequently fills again. All observers who have met with these cases are agreed that all attempts at extirpation would be met with considerable danger. In addition to the hyoid bursa, subcutaneous bursal cysts are sometimes found over the thyroid, and even as low as the cricoid cartilage.—*Med. Times and Gaz.*, Feb. 11, 1871.

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Colotomy and Operation for Fecal Fistula.—Mr. Christopher Heath, on Feb. 4th, at the Hospital for Women, Soho-Square, performed colotomy for malignant disease of the rectum. While the patient was being brought under the influence of chloroform, Mr. Heath explained that the patient had only on the night before come into the hospital. There had been a scirrhous condition of the rectum for a long time, the disease being situated three inches from the anus, and being attended by the usual symptoms of painful defecation, and occasional losses of blood. Mr. Heath had long since advised colotomy, but the patient refused, and it was only two days ago, when, absolute obstruction having been present for a week, stercoraceous vomiting had already set in, that Mr. Heath was sent for, and the woman submitted to the operation. Mr. Heath referred to a similar operation performed by him on the previous Saturday, in which, however, the conditions were more pleasant, as the state of the lower bowel rendered it possible to distend the colon with water, and so render it easily and cleanly reached. Here, probably, also, the bowel would be distended, but with feces, which would make the operation of a more disgusting character. Before making his incision, Mr. Heath marked with ink, on the left loin, a vertical line, half an inch behind the midpoint of the crest of the ilium, which, he said, was an infallible guide to the colon. He then dissected straight down on this line, at once exposed the distended colon, and before opening it, passed two sutures through the bowel and skin, keeping them loose, but attached on either side to the edge of the wound. Then, the gut being drawn up and opened, the middle of each thread was pulled up, cut, and the opened bowel at once stitched to the lips of the wound without further trouble. There was an immediate escape of feces, and as this subsided, a quantity of pulled

oakum was packed over the wound, and the patient returned to bed. By this method of procedure, the operation was conducted with a precision, rapidity, and cleanliness which we have not before witnessed.—*Medical Times and Gazette*, March 4, 1871.

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Case of Tetanus Neonatorum treated with Chloral Hydrate; Recovery.—Dr. Widerhofer showed lately to his class at the Children's Hospital, Vienna, a child of three months old, which was attacked by tetanus neonatorum at the end of the first week after birth, and was treated with chloral hydrate in doses of one and two grains at the time of each onset of convulsions. It was in danger for a fortnight. During the intermission of the spasms it was fed from the breast by its mother. It is now a fine, healthy-looking child. This is the sixth case (out of ten or twelve) that Dr. Widerhofer has had of recovery under treatment by chloral. Under all other methods all his previous cases died. Considering that Vogel, and other great German authorities on children's diseases, had quite recently never seen a case of this affection recover, such a success must be taken to indicate a real advance in therapeutics. Dr. Widerhofer gives from two- to four-grain doses of chloral by the rectum, if the infant cannot take it by the mouth.—*Lancet*, March 18, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Gonorrhœa by Warm Water Injections.—Dr. John O'Reilly contributes a short article on this subject to the *American Practitioner* (April, 1871). The conclusions at which he arrives are the following:—

1. That gonorrhœa yields to local treatment, and even water injections.

2. That water injections or medicated lotions owe their efficiency to their frequent application.

3. That the common small syringe should be done away with in treating this disease, and none used but those throwing a continuous stream.

4. That large injections, by fully distending the mucous membrane of the urethra, insure a speedier cure than those less copious.

This method of treatment Dr. O'Reilly instituted in the Venereal Hospital established at Nashville in connection with the army of the Cumberland. The patients were ordered the usual diet of the hospital, with no drinks but water, and the nurse was directed to inject freely tepid water into the urethra every hour, except at night, during which period the patients were instructed, if they awoke, to use the injection themselves. The result was that in five days the patients were pronounced well, the discharge having ceased in forty-eight hours after the treatment was commenced.

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The Pennsylvania Hospital.—The No. of the *Medical Times* for April 15, 1871, contains a sensible article respecting this useful and venerable institution. Our contemporary justly states that "there is no other institution in Philadelphia in which the interests of the medical profession have centred for so long a time as" in it. From 1766 down to the present time, a period of upwards of a century, clinical lectures have been given there.

"The prosperity of Philadelphia as a seat of medical teaching has been largely owing to the excellence of the clinical instruction given at the hospital, and the graduates of her schools have always recalled with pleasure the time spent within its walls. With such pleasant recollections of its greatness, we cannot look with equanimity or indifference upon its present decline in popularity with students.

"In the early part of November, 1869, nearly five hundred tickets were sold, and we are told that on one or two occasions that number of students actually assembled in its amphitheatre—constituting, it is believed, the largest class in attendance upon clinical lectures in the world. During the past winter less than two hundred students attended the clinics. Why has this change occurred? More favourably situated than any other hospital in the city, within ten minutes' walk of the two great schools of medicine and

of the homes or boarding-houses of the students, with precisely the same medical staff, many of the members of which are popular teachers, and affording opportunities for clinical study unsurpassed elsewhere, the change since last year seems incomprehensible.

"We can only regard it as one of the results of the action of the contributors to the hospital, who, at their last annual meeting in May, practically decided that the medical staff, comprising the only officers of the hospital who are at all fitted to decide questions pertaining to medical teaching, should have no voice in determining them."

If the contributors to the hospital desire to restore the former renown of the institution, they should in its management defer more than they have latterly done to the judgment of their medical staff, as was formerly the case in the palmy days of Morgan, Rush, Physick, Wistar, and their contemporaries. Indeed it was a great mistake in the original organization of the hospital that its medical staff were not given a vote in its management. They should be *ex officio* members of the Board of Managers, for it must be evident that in all matters, except merely those of finance, they are more competent, from their education and training, to decide what is best for the interest of the sick and the advantage of the institution as an educational one than can be gentlemen brought up to mercantile pursuits.

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South Carolina Medical Association.—This association held its annual meeting in the city of Charleston on the 4th, 5th, and 6th of April last. Several interesting papers were read, and the following officers were elected for the ensuing year:—

F. Peyre Porcher, M.D., Charleston, President; R. W. Gibbes, M.D., Columbia, First Vice-President; A. P. Wylie, M.D., Chester, Second Vice-President; D. S. Price, M.D., Marion, Third Vice-President; T. Grange Simons, M.D., Charleston, Recording Secretary, *vice* J. S. Buist, declined re-election; S. Baruch, M.D., Camden, Corresponding Secretary, *vice* F. P. Porcher, elected President; F. L. Parker, M.D., Charleston, Treasurer.

After the transaction of other important business the association adjourned to meet in Columbia on the third Tuesday in April, 1872.

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Medical and Surgical Memoirs.—Joseph Jones, M.D., Professor of Chemistry, Medical Department, University of Louisiana, is preparing for the press a work embracing his investigations during fifteen years into the Causes, Geographical Distribution, Natural History, and Treatment of Intermittent, Remittent, and Congestive Malarial Fevers, Yellow Fever, Typhoid and Typhus Fevers, Smallpox, Spurious Vaccination, Measles, Pneumonia, Diarrhœa, Dysentery, Scurvy, Tetanus, Cerebro-spinal Meningitis, Diseases supervening upon Gunshot Wounds, Pyæmia, Hospital Gangrene, Erysipelas, etc. The work will be published as soon as a sufficient number of subscribers have been obtained

Those desiring to become subscribers should forward their names to Joseph Jones, M.D., Glass Box 1542, New Orleans, La.

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Obituary Record.—It is with regret that we record the death at Cincinnati, Ohio, on the 22d of March last, at the mature age of 76, of Dr. W. T. Taliaferro, formerly of Maysville, Kentucky, but for a number of years past a resident of Cincinnati. He was a skilful ophthalmologist and highly estimable gentleman.

FOREIGN INTELLIGENCE.

Therapeutic Value of Iodine in the Treatment of Syphilis.—Mr. Berkeley Hill, of the Male Lock Hospital, considers it of first importance, in estimating the power of iodine to subdue syphilis, to determine the stage during which the drug is most serviceable, and what are the forms in which the disease betrays itself during that stage.

Iodine is, he says, unquestionably of high value in all the skin affections characterized by prominent or deeply-set tubercles in the skin, and those marked by ulceration rather than by desquamation. In the visceral forms of syphilis

also, in periosteal and osteal affections, and in muscular tumours, the extreme value of iodine is beyond doubt. This indisputable effect of iodine in certain forms, and the prejudice against mercury, have led many practitioners to employ iodine for all the phenomena of syphilis. This Mr. Hill believes to be a mistake, for two reasons. The first: that he has never been able to trace any result from the exhibition of iodine either for the initial sore or for the roseolous and papulo-scaly eruptions on the skin. Undoubtedly, these symptoms may disappear while iodine is being taken; but it has not yet been shown that they do so with greater rapidity than when the patient is subjected to no specific treatment whatever. The second: that he is strongly convinced that the earlier the disease is controlled, the more likely is the patient to escape a tedious course and the dangerous sequelæ of syphilis. Consequently, he regards the iodine treatment of early syphilis as a loss of valuable time, and as an exposure of the patient to the chance of ultimate, and possibly avoidable, suffering. The converse is, however, unfortunately not always true: the best and most careful treatment of syphilis at the outset is not a perfect safeguard against a severe course of the malady. Nevertheless, every year increases his confidence in the protective value of a judicious early treatment.

Mr. Hill believes that iodine is generally given with advantage to feeble persons, whose eruption is pustular rather than bullar; but even here he thinks it possible that the stimulant effect of iodine is the chief benefit derived from the drug, and mercury should follow the iodine as soon as the restored vigour of the patient will allow; and if, in such cases, iodine alone is relied on, the disease commonly recurs in the same or some other form. Iodine, therefore, he considers useless in all initial sores, and in early scaly or muscular eruptions, but often serviceable as a preliminary to mercurial treatment for debilitated persons.

But even when unquestionably appropriate, it should always be followed by mercury. When the patient is apparently restored to health, he should at once begin a course of small doses of mercury, given continuously, or with occasional short intervals of iodine, and lasting four or even six months. The dose of mercury need not be sufficient to produce any soreness of the gums; slight sponginess is all that is needed. A fifth or a fourth of a grain of perchloride in the twenty-four hours, given with cinchona solution and hydrochloric acid, is very effectual. Ammonia should not be used in any form with the mercury, for it has been shown by Mr. Martindale, teacher of practical pharmacy and dispenser in University College Hospital, that the perchloride, when mixed with ammoniacal salts, is gradually but completely precipitated from solution as ammonio-chloride; hence, though this precipitate would be dissolved in the stomach and produce its proper effect, the chance of its remaining as sediment at the bottom of the bottle renders ammoniacal solutions of mercury uncertain and unfit for internal use. Simple distilled water dissolves the perchloride quite sufficiently for this purpose.

Iodine is also useful, when given after a mercurial course, to prolong the influence of mercury which has been given early in the disease. In such cases it will frequently control even scaly eruptions, which otherwise would be slow to subside. This effect has been attributed to the fact of the mercury, which has been deposited in the tissues, being redissolved into the circulating fluids.

The modes of giving iodine vary much with the individual. Small doses of two or three grains, three or four times daily, should be combined with some aromatic or astringent tincture or infusion to prevent the irritation of the alimentary canal that sometimes occurs. But these small doses soon lose their effect, and must be gradually increased by about one-third at successive steps. This rule holds good also for large doses. If a patient ceases to derive benefit from twenty grains, the increase should at once be made to thirty, for a smaller addition to the dose seldom has any effect. The augmentation should be continued until the disease has disappeared, or until symptoms of iodism show that no more can be borne. In the latter

event the use of iodide should at once be discontinued for a short time, and subsequently resumed in some other form. For example, if iodide of potassium has been previously used, the sodic or ammoniac iodide should be tried, and that in half the former dose. Sometimes it happens, after taking long courses of iodide of potassium, that the stomach grows intolerant of the alkali, the tongue becomes white and furred, the stomach loathes food, and the syphilitic symptoms cease to show any abatement. This condition is often not comprehended by practitioners, who abandon the iodide (or are themselves abandoned by the patient), and take to mercury or some other drug, which in such a state of the alimentary canal can command no success. A dose of blue-pill and colocynth, with a few days' treatment with nitro-hydrochloric acid, and complete abstinence from alcoholic drink, will, however, speedily restore the appetite, clear the tongue, and render the patient again able to take the iodide. Mr. Hill has known a disordered stomach to make iodine inoperative, even when that drug had been taken for only a short time. In one case he was applied to by a medical man for advice about a very painful node on which iodide of potassium produced no effect. He found that the stomach was considerably deranged, and prescribed some simple remedy for its condition before making a further attempt with the iodide. Then, on the iodide being resumed, the patient was immediately relieved of the pain and swelling, which it had before failed to influence. Again, the use of iodine can sometimes be prolonged, after the system has tired of it, if combined with sarsaparilla, of which the most useful forms are, in Mr. Hill's opinion, the liquid extracts of Bell or Squire. One, two, or even three drachms should be given in half a pint of water, with the requisite dose of iodide, about midway between, or two hours after, meals. Ammonia very greatly assists the effect of iodide of potash in debilitated patients. It is a more valuable adjunct than the salts of iron even. Four or five grains of the sesquicarbonate may be added to the draught of iodide. Bromide of ammonium added to the iodide has apparently also a good effect in the nervous affections of syphilis. With regard to the form of iodide to be employed, the salts of potassium, sodium, and ammonium alone can be trusted to produce marked effects of iodine; but which of these is preferable Mr. Hill hesitates to decide. The taste of each of them is, perhaps, equally disagreeable; but the sodic and ammoniac forms, having smaller equivalents of alkali, furnish a larger amount of iodine, weight for weight, than the potassic. Empirically, he has not been able to detect any particular advantage in any one of these salts over the others. Either of them, if pushed too far, will produce iodism; and the same patient will at one time bear one better than another. He has not been able to detect any difference between the effects of these three salts, except that each is useful for ringing a change in cases where the use of iodine must be long continued.

The toxicological effects of iodine are various. That most commonly complained of is irritation of acne pustules in persons subject to that complaint. The appearance of this symptom always indicates a short course of acids; so do the dry, red tongue so well described by Mr. L. Parker, coryza, and the other decided signs of iodism. Flat papules and flat pustules of the skin are so rarely produced that they should never be waited for as a sign that iodine has been pushed too far. Nevertheless, Mr. Hill has seen them produced on two occasions when very few grains of iodide had been taken. The subjects belonged to a rare class, which appears to be constitutionally unable to take iodine in any form.—*Lancet*, March 4, 1871.

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Treatment of Palpitation of the Heart.—Dr. Fred. B. Nunnely states (*Lancet*, Feb. 25, 1871) that of all remedies, he has found the subcutaneous injection of morphia to be the most trustworthy; it nearly always alleviates, and very frequently cures, the complaint after a few repetitions. One-twelfth to one-tenth of a grain is a sufficient dose to begin with, and there is little occasion to exceed this quantity. The injection should be re-

peated every third or fourth day. Though the arm is the most convenient place to insert the needle, the injection is sometimes more effectual at the præcordia. When morphia fails, or is not tolerated, atropia may be substituted; but is not, I think, so useful. If the prick is objected to, the morphia may be applied to the derma denuded by a small blister raised with ammonia, as Trousseau recommends. The hypodermic application of morphia has the additional advantage of relieving pain.

Local applications are of great service. Belladonna and its preparations stand in the first rank of these. The ordinary belladonna plaster, of good size and renewed every week or ten days, is very convenient and effective. It presents three special advantages: it protects the chest walls, which are tender, from the pressure of the clothes, and seems to deaden the painful impulse of the heart; besides this, it impedes slightly the free movement of the parts, and thus obviates the muscular pain often present. Another good application is a mixture of equal parts of liniment of belladonna and of liniment of chloroform, sprinkled on cotton-wool. Hot linseed and mustard poultices are soothing, and are easily obtained.

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Gastric Juice Enemata in Cancer of the Rectum.—Dr. D'Arpem, of Elba, has reported (*Lancet*, March 18, 1871, from *Imparziale* of Florence, March 1, 1871) a case illustrating the marvellous effects of this juice in cancer. The patient is a married woman, aged thirty-eight, who suffered, according to the author's diagnosis, from carcinomatous ulceration of the rectum and cervix uteri. After having controlled the uterine hemorrhage with perchloride of iron, Dr. D'Arpem was in doubt as to the treatment of the malignant ulceration, when he heard of the views of Professor Schiff on the subject. The latter had for some time advocated the use of gastric and pancreatic juice in cancer.

Being applied to, the professor furnished the author with artificial gastric juice, and advised injections into the rectum of about seven fluidrachms of the juice daily. Much pain was experienced from the first injection, but this was lessened by the use of some almond oil. The seven drachms were now divided into three parts, injected separately three times a day. This was continued for twenty days, when considerable improvement had taken place, both as regards the rectum and the womb. The patient was now so well as to be able to perform a journey with her husband, and on her return the cicatrization of the ulcer was complete. She had continued the enemata at longer intervals during her absence, and she now presented all the outward signs of health. Such are the facts related by the author. If the diagnosis were perfectly reliable, we might harbour the hope that the specific for cancer has been found. But the case is isolated, and does not present the proper guarantees as to diagnosis. Nor is it likely that numerous trials will be made in the same direction.

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Chloral Hydrate.—Dr. Richardson, in one of his recent lectures on experimental and practical medicine (*Lancet*, Feb. 11, 1871), made the following interesting observations on chloral hydrate, in reply to questions that are continually presenting themselves to the mind of the practitioner.

What is a dangerous and what is a fatal dose of hydrate of chloral? The largest dose I have known to be taken is one hundred and twenty grains. This dose produced a prolonged and dangerous coma, but recovery ultimately followed. I think we may consider a hundred and twenty grains, as a maximum dose for an adult, dangerous, but not of necessity fatal. Beyond a hundred and twenty grains the danger increases, and a hundred and eighty grains may be considered a dose that would prove, in the majority of cases, positively fatal.

What quantity of hydrate of chloral can be given with safety in divided doses during a stated period of time, say of twenty-four hours? Judging from the physiological effects of hydrate of chloral in relation to dose, and to order of phenomena in relation to time, I should infer that the body cannot decompose and throw off the hydrate more rapidly than at the rate of

from five to seven grains per hour. There will be difference according to age of person, the temperature to which the body is exposed after the dose has been taken, and the largeness of the dose, a small dose being disposed of quicker in proportion than a large one. But the variation is not such as to alter materially the rate of action from the estimate given. I should consider, consequently, that a hundred and twenty grains, administered, even in divided doses, in twenty-four hours, would be the safe limit of administration. In the treatment of tetanus this proportion has been exceeded, but not, I think, to the safety of the patient; for the fact that the hydrate of chloral overcomes or reduces the spasm is no safeguard against its own poisonous effects. From what I know, I conclude that the hydrate of chloral can be given to the extent of overcoming the severest spasm; but if the dose be carried too far, with the determination of removing spasm at all risks, the success may easily be bought at the expense of a fatal narcotism from the remedy.

Does the frequent administration of hydrate of chloral lessen or increase the danger of the administration? On this question I am forced to state that the frequent administration of the hydrate of chloral, though it may suggest greater confidence in it on the part of those who take it, increases the danger from an excessive dose. Hydrate of chloral differs from opium in this respect, opium produces chronic symptoms peculiar to itself, but the dose may be steadily increased without any immediate danger from the increase. Hydrate of chloral cannot be used in this accumulative way without danger. In a word, although a person may become habituated to hydrate of chloral, there is a limitation of the quantity to be taken safely, which limitation is not materially modified by persistence in the habit of taking it, but rather the reverse.

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Death from Hydrate of Chloral.—Dr. H. W. Fuller reports (*Lancet*, March 25, 1871) a case in which thirty grains of chloral twice produced alarming symptoms, and another in which the same dose caused death.

He concludes: Judging from what I have learned from various members of our profession, I believe that although fatal consequences may rarely follow a dose of thirty grains of the chloral hydrate, yet that unpleasant, if not dangerous, symptoms are not unfrequently experienced. Dr. Tuke informs me that in a man whom he saw suffering from the effects of intemperance thirty grains very nearly proved fatal, the symptoms of depression and failure of the heart's action being most alarming; and Mr. Fred. Webb, of Maida-vale, has given me the particulars of another case in which an elderly man very nearly lost his life from the effects of thirty grains. The faintness, pallor, and depression of the heart's action were excessive, and for some time Mr. Webb was in doubt whether he would be able to sustain the pulsations of the heart until the effects of the chloral had passed.

Doubtless these cases are quite exceptional, and are met with only in about the same proportion as cases of death from the administration of chloroform. But the facts I have cited are sufficient to prove that such cases are more frequent than is commonly supposed. Further, they inculcate the necessity for caution in the administration of the drug; and they point to the conclusion that thirty grains form too large a dose for ordinary use, and especially for a patient in whom the effects of chloral have not been previously tried. As a hypnotic in nervous restlessness, ten or fifteen grains ordinarily prove efficacious; and I have not seen or heard of any unpleasant symptoms following these doses. But the cases above recorded prove that larger doses, though usually harmless and often marvellously efficacious, are not unattended with risk; and now that the public are beginning to dose themselves with chloral, as they have done of late years with chlorodyne, this important fact cannot be too widely known.

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Metachloral. — Dr. Richardson exhibited to the Medical Society of London (March 13) this substance. It is a white powder, insoluble in water and alcohol. It is believed by Dr. Richardson, from experiments made on the lower animals, to

possess mild narcotic properties. Metachloral is isomeric with chloral. It is produced when chloral hydrate is brought into contact with sulphuric acid. Chloral, also, may be changed into metachloral spontaneously when it is kept for a long time in a stoppered bottle, or when a quantity of water insufficient to produce the hydrate is added to it. Heat converts metachloral into the liquid chloral, which becomes the hydrate on the addition of a sufficient quantity of water. Owing to its affinity for water, chloral is a caustic, and Dr. Richardson thinks that this fact, taken together with that of its after soothing effects, may be turned hereafter to practical value. The specimen of metachloral exhibited by Dr. Richardson was prepared by Dr. Versmann by bringing chloral hydrate in contact with sulphuric acid at 140° Fahr. By treating it with alkalies, metachloral yields a formate and chloroform.—*Med. Times and Gaz.*, March 18, 1871.

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Deaths from Chloroform.—A patient had been admitted into the Royal Infirmary of Edinburgh for dislocation of the hip, which was being reduced when the fatal occurrence took place. At the post-mortem no organic lesion was discovered. —*British Medical Journal*, March 11, 1871.

In the *British Medical Journal* (March 25, 1871) is recorded the case of a man who was operated upon for fistula. About one drachm and a half of chloroform was administered on a cone of lint; during the operation the breathing and pulse suddenly ceased. All the organs of the body were found to be healthy, excepting that there was an immense amount of fat.

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Smallpox and its Prevention.—Dr. Crisp read before the Medical Society of London, at a late meeting, a paper on the above subject, which at this time is especially valuable and interesting. The subjoined are some of the conclusions arrived at by the author: That no deleterious effect is produced upon the human constitution by the introduction of cow-pox matter—an inference greatly strengthened by the fact that, since the introduction of vaccination, the population of the United Kingdom has nearly doubled. That government hospitals should be established in the metropolis, in suitable localities, and provided with proper vehicles for the conveyance of patients, and with proper heat-chambers for disinfection. That, looking to the important fact that in ten years—1851 to 1860—42,071 deaths occurred in England and Wales from smallpox, and that 37,007 of these deaths were in young persons under 13 years of age, the recommendation given by the Privy Council and by the London College of Physicians should not be followed, but that where there is danger of infection, children of all ages should be revaccinated. That there is no sufficient reason why lymph, during the time of an epidemic, when it is often difficult to procure, should not be taken from adult persons, provided they are free from disease and the vesicle presents a normal appearance. That more extended observations are needed before we can come to the conclusion that the amount of exemption from smallpox depends upon the number of marks upon the arms from previous vaccination.

The general opinion in the profession is distinctly opposed to the use of revaccination lymph at all, and the rule that hence has arisen is one which should generally be observed. Still there is no scientific reason why revaccination lymph should not be availed of occasionally under the conditions mentioned by Dr. Crisp—viz: 1. During an epidemic season (when, by the way, revaccination appears to be unusually successful). 2. When primary lymph cannot be procured. 3. When the vaccinifer is absolutely free from disease or constitutional taint. 4. (Most emphatically) When the revaccination vesicle exhibits in its course and appearance all the characters of a normal primary vesicle. 5. On condition that the lymph be taken about the sixth day, or before there is a trace of areola.—*Med. Times and Gaz.*, March 11, 1871.

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Efficacy of Revaccination.—Dr. Carpenter, of Croydon, at a recent meeting of the local Board of Health stated that at the recent outbreak of smallpox at St. George's

Hospital, where seventeen cases occurred by contagion from a case accidentally admitted, and fourteen days after its removal, every servant, nurse, medical man, and student connected with the establishment was immediately vaccinated, and although the seventeen patients were treated in the hospital, not a single case occurred afterwards.

Again, that in his own private practice, and that of other medical gentlemen in Croydon, who being careful that their whole *clientile* were properly vaccinated, had not had a single person fall a victim to the disease.—*Med. Times and Gazette*, April 8, 1871.

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Heifer Vaccination.—It is stated (*Med. Times and Gazette*, April 1, 1871) that no one of any authority, that we know of, has advocated the substitution of heifer vaccination for vaccination from arm to arm in this country [Great Britain].

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Smallpox in India. — Dr. De Renzy, Sanitary Commissioner of Punjab, states that in that province, with a population of 5,000,000, the deaths from smallpox are never less than 20,000 a year. In 1869, they numbered 53,195. Contrast these terrible totals with the smallpox mortality of England, in which, with its population of 21,000,000, the average of smallpox deaths does not now exceed 5000 a year, though previously to the introduction of vaccination it was quite as high as it is now in the Punjab. But it is not merely in the saving of life that the benefit of vaccination consists. The amount of physical disfigurement caused by smallpox in the Punjab is enormous. Any person walking through the streets of a Punjab city is struck by the immense proportion of persons blind of one or both eyes—a calamity caused, in ninety-nine cases out of a hundred, by smallpox. Europeans, who, as a rule, are tolerably well protected by vaccination, suffer very little, though they live in the midst of a never-ending epidemic; and natives have everywhere remarked the immunity of Europeans from the injuries to the eyes and other disfigurements to which they are themselves so subject.—*British Medical Journal*, April 8, 1871.

Fibrous Tumour of Heart.—Mr. Wagstaffe presented to the Pathological Society of London an exceedingly rare specimen of probable fibrous tumour of the heart, which occurred in the practice of the late Mr. Nunn, of Lyndhurst. It was removed from the body of a child three months old. The child was quite healthy until a few weeks before its death, when it had occasional transitory spasms, in one of which it died suddenly. The tumour was situated in the substance of the septum ventriculorum. Microscopically, it appeared to be mainly composed of well-developed white fibrous tissue. Mr. Wagstaffe said there was only one case on record in the *Transactions* of the Society of a true simple tumour of the heart, and that was of a peculiar cystic form. He considered the specimen, therefore, unique. Its occurrence in a child three months old without interference with nutrition, and with such slight symptoms, made it a case of extreme clinical interest.—*Brit. Med. Journ.*, Mar. 11, 1871.

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Obituary Record.—We learn from the *British Medical Journal* (March 25, 1871) that among the victims whom the medical profession has furnished in connection with the recent Franco-German war, have been two men of more than common note —Professor Albrecht Wagner of Königsberg, who died at Dole on February 15th; and Professor Felix von Niemeyer of Tübingen, who has died lately at Nancy. The cause of death in both cases was typhoid fever, contracted in the discharge of duty. Dr. Wagner was well and favourably known in Germany for his works on the Resection and Regeneration of Bones (translated a few years ago by the New Sydenham Society), on Hydrophobia, Diabetes in connection with Carbuncle, Resection of Nerves, etc. Dr. Wagner had been attached to the army of General von Manteuffel as surgeon-general. The name of Dr. Felix von Niemeyer has become well known among us through the translations of his excellent *Text-Book of Practical Medicine* and his *Lectures on Phthisis*. He was Director of the Field Ambulance at Nancy. In the deaths of Wagner and Niemeyer, a great loss has indeed been sustained by medical science.

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Dr. Blandford's book well meets the prevailing deficiency, and is one of that class, unhappily too small, which prove a real blessing to the busy practitioner who has no other time for reading but those odd moments which he can catch in his brief intervals of leisure. It is so free from defects and is so fair a representation of the most approved views respecting insanity, that we find in it small occasion for criticism, and can do little more than commend it as an admirable manual for practical use. We end as we began, in heartily recommending it as a most useful and reliable guide to the general practitioner.—*Am. Journal Med. Sciences,* April, 1871.

HENRY C. LEA, Philadelphia.

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GUERSANT ON SURGICAL DISEASES OF INFANTS, ETC., 16 PAGES.

CLINICS.

CLINICAL LECTURES.

Clinical Lecture on the Common Diseases of the Breast. By CHRISTOPHER HEATH, F.R.C.S., Surgeon to the Hospital for Women, and Assistant Surgeon to University Hospital.

GENTLEMEN: The breast being one of the organs in close relation with the procreative organs of the female, its diseases come properly under the cognizance of the medical officers of a charity devoted to the diseases of women; I need not, therefore, make any apology for having selected these affections as the subject of this course of lectures. Although, for convenience sake, and by the general consent of the profession, the more severe forms of breast disease requiring local operative interference are allotted to the surgeon, yet the simpler though not less important affections more frequently come under the notice of the accoucheur, being often connected with some disturbance of the function of lactation. It must, however, occur to every one, whatever his department of practice, to be consulted occasionally with respect to conditions of the breast which have excited notice, and perhaps alarm, in the patient's mind; and it is most important that an early decision should be arrived at as to the nature of the affection in all cases, since the treatment, to be of avail, must be adopted before any great amount of structural alteration has taken place. Undoubtedly, pain in the breast is often but a symptom of uterine or ovarian irritation, and its relief can only be effected by attention to those organs; but I do not propose to enter into these questions, which have

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been already discussed by my colleagues, and shall confine my attention during the present course to those structural changes in the mamma itself which may be strictly classed under the term "diseases of the breast."

Omitting any lengthened allusion to those anomalies of development of the breast, as regards position of the organ itself, the development of an unusual number of nipples, &c., which are rather matters of curiosity than of practical importance, I will pass on to a condition of *atrophy* of the breast, which is a frequent cause of serious trouble to both patient and practitioner. I do not mean atrophy of the breast itself, for this is of rare occurrence, except that senile atrophy which is commonly witnessed with advancing years, but atrophy or want of development of the nipple, which is a not infrequent cause of inflammation, and consequent abscess, when the organ is called upon to fulfil its functions in nourishing a child. It has been laid down that this inversion or want of prominence of the nipple is the result of pressure from a tight corset or dress, but I do not believe this to be the case; I look upon it rather as a congenital malformation, and I venture to call your attention especially to it because I believe that but little notice is directed to it until often too late, whereas with care it may be remedied. Every one is acquainted with the enlargement of the breast and the development of the areola which take place in pregnancy, but it is not always remembered that the nipple is an erectile organ, and that its base is surrounded with a considerable quantity of involuntary muscular fibre, which, when properly developed, gives the healthy prominence to the nipples. If friction with oil, or any simple liniment, were systematically applied by primiparæ to their nipples during the later months of pregnancy, the vascularity of the nipple itself would be excited, the development of muscular fibre, and consequent projection of the nipple, would be stimulated, and the patient would be saved much worry from fruitless efforts to draw the nipple out after childbearing; and would, consequently, be much less liable to suffer from sore nipples and all their painful consequences.

That friction will, if prolonged, induce hypertrophy, not merely of the nipple, but of the breast itself, is shown by a case which came under my notice some years back, in which the lascivious manipulations of a lover, extending over many months, had resulted in a veritable hypertrophy of the whole organ. This simple *hypertrophy* of the breast—the existence of which has been denied by some authorities—is an undoubted fact, and seems to occur in young unmarried persons without obvious cause. Mr. Erichsen has recorded a case of the kind in a girl of fifteen, in whom the breast was greatly hypertrophied; while Manec, of La Charité, in Paris, met with one in a girl of seventeen, both breasts being affected, and weighing after removal 15 lb. and 17 lb. respectively.

I saw a similar case in the practice of Sir William Fergusson some years back, both breasts having grown to such a size as to be a burden to the patient, who gladly submitted to amputation, after having tried every other method of treatment unsuccessfully. It is the general experience in all these cases, I believe, that amputation is the only means of cure. In the first case I mentioned, where the hypertrophy was reasonably presumed to have depended upon sexual excitement, "clitoridectomy" was performed by a surgeon who at that time upheld that operation as a panacea for most female ailments, but without any benefit to the mammary enlargement. Whether unsuspected sexual excitement may have been the cause of the enlargement in other cases of the kind, I am unable to say.

It is, however, when the breast has to enter upon the function of lactation that it becomes of most importance pathologically; and I shall now proceed to speak of those disorders which occur during or after the completion of pregnancy.

And first of *Sore Nipples*. These may depend upon some peculiarity in the constitution of the mother, or state of the child's mouth, but are more frequently the results of simple want of care—first, in not preparing the nipple; secondly, in

not caring for it during lactation; and thirdly, in leaving it too long in the child's mouth, the infant being permitted to sleep with the nipple in its grasp. The preparation of the nipple, particularly in first pregnancies, I have already mentioned; but the hardening of the delicate skin covering the organ by bathing it with weak spirit should not be omitted in every pregnancy. The care required during lactation is principally that the nipple should be dried after each period of suction; and when there is an involuntary flow of milk in the intervals, the use of a properly shaped breast-glass serves to prevent the nipple being constantly sodden by contact with wet under-linen.

That the tender, moist skin of the nipple may be infected by the secretions of the child's mouth is, I think, undoubted. Thus, a child with thrush in the mouth may induce a painful condition of the mother's breast; whilst a child labouring under congenital syphilis will very probably produce mucous tubercles on the breast of a healthy nurse, whose system may thus become infected. The communicability of secondary syphilis is so thoroughly ascertained, that it appears almost unnecessary to insist upon it now-a-days; and the examples of its communication from nursling to nurse have unfortunately been too frequent, especially in France, to admit of argument. Mr. Henry Lee holds that the natural secretions of the body, when the structures producing them are in a healthy state, cannot be the means of communicating syphilis to another person, although the patient from whom these secretions are derived be constitutionally syphilitic, and quotes (*Holmes's System of Surgery*, vol. i.) in illustration the case of a healthy woman who nursed a syphilitic child with *one* breast, and became affected with constitutional syphilis; whilst her own child, nursed with the *other* breast, remained healthy. This doctrine is, however, too doubtful to be implicitly relied on in practice, in my opinion. It would be the duty of a practitioner to refuse to sanction the placing of a confessedly syphilitic infant with any nurse, unless the latter fully understands and is prepared for the risk she undergoes; and should syphilitic symptoms develop after nursing has commenced, it should be immediately arrested, and the child be brought up by hand, rather than allow the nurse to become infected. When a mother is suckling her own child in which syphilitic symptoms develop, it is, I think, of small importance that she should continue to nurse it, for the poison is already in her system, and it will of course be necessary to adopt specific treatment for both mother and child. At the same time, it will be well to protect the nipple with a shield. I have no faith in treating the child through the mother's milk, any more than in the ancient plan of rubbing mercurial ointment into the udders of goats with a view to rendering their milk curative of syphilis. In the syphilitic infants the disease must be treated with mercury, and most satisfactorily by inunction.

In the treatment of the ordinary chapped nipple all sorts of nostrums have been advocated, but I have found nothing so satisfactory as a five-grain solution of nitrate of silver, carefully pencilled on with a camel's-hair brush after each act of suckling. The employment of spirit of nitrous ether as a vehicle, instead of water, has the great advantage of giving a lotion which dries rapidly, and which is not repelled by the greasy condition of the nipple. The use of a shield, if the child has an aphthous mouth, or is prone to bite, gives relief, but will not effect a cure without local medication.

The first effect of a soreness of the nipple sufficient to prevent the child being put to the breast is *engorgement* of the organ with milk. Under these circumstances the breast becomes distended and tense, and stands out prominently from the chest-wall. Soon, if unrelieved, the skin becomes œdematous, and inflammation will certainly ensue unless relief be promptly afforded. If the infant, or possibly an older child, can empty the breast through a shield used to protect the tender nipple, the urgency of the case will be at once relieved; but if not, some form of breast-pump must be employed, or recourse be had to gentle but steady pressure, with both hands embracing the

breast, and thus squeezing out the milk. Anything like violent manipulation of an engorged breast is much to be deprecated; but steady and even pressure will often give relief. It is certainly advisable to diminish the secretion of milk in the breast; and for this purpose nothing is so certain or satisfactory as the external application of extract of belladonna mixed with equal parts of glycerine. The effect of belladonna, freely applied in this manner, is not merely to relieve pain, but, by causing contraction of the capillaries, to diminish the quantity of blood in the organ and the amount of secretion.[1] In addition to the local remedy, means should be taken to act upon the bowels; and since cases of sore nipples frequently occur in females exhausted by over-suckling, the combination of tonics with hydragogue cathartics is very useful. The formula I generally employ is, sulphate of quinia, one grain; sulphate of magnesia, four drachms; dilute sulphuric acid, five minims; pimento water, one ounce: every six hours.

If engorgement goes on unrelieved for over twenty-four hours, inflammation is pretty certain to supervene, the constitutional symptoms of which are generally well marked: the patient's skin is hot, there is great pain and tension of the breast, the pulse is hard and frequent, and the tongue coated. If seen before the occurrence of a rigor, by which the formation of matter is generally announced, the treatment for this condition will be the same as that for simple engorgement, since one runs almost imperceptibly into the other. In addition to the use of belladonna locally, I have found the greatest benefit from the application of warmth and moisture by means of a linseed poultice placed over the belladonna; and it is most important that the breast should be thoroughly supported by a sling, or, what I prefer, a broad strap of plaster affixed to the shoulders, and carried below the organ. In debilitated patients, in whom inflammation of the breast is most generally seen, any local or general depletion is uncalled for; but the administration of the tincture of aconite, in frequent and small doses (two minims every two hours), will do much to relieve the feverish condition of the patient, and to promote a healthy moisture of the skin.

Suppuration is most common in the substance of the breast itself, though an abscess occasionally forms near the nipple, and still more rarely, at least during lactation, beneath the breast, in the connective tissue between it and the pectoral muscle. Since suppuration involves ordinarily only a portion of the gland-tissue, the secretion of milk goes on to a certain extent, and a child may even be put to a breast in which an abscess already exists. The matter never finds its way along the lactiferous tubes to the nipple, for these are blocked by inflammatory deposit at a very early period, but it tends to burrow through the breast, and to inflict very serious permanent injury upon it unless early evacuated.

The diagnosis of an abscess deep in the substance of a breast is by no means easy in all cases; and the so-called *tactus eruditus* of the surgeon has no better opportunity for its display than in its detection. The period for which the disease has lasted, and the œdematous condition of the integuments, will justify an incision even when fluctuation may be doubtful; and, fortunately, a mistake is of little consequence, since the relief of tension by the slight hemorrhage and draining away of serum consequent upon the incision will be as great as if matter had been evacuated. It is often difficult, at least in hospital practice, to persuade a patient to purchase permanent relief from all her sufferings by submitting to a momentary infliction of pain; and I find it advantageous, in explaining the treatment to the patient or her friends, to avoid most carefully the use of the word "lancing." A woman who protests loudly against being "lanced" will permit all that is necessary under the name of a "prick" or "puncture," particularly if the surgeon is pretty rapid in his movements, and avoids making any display of instruments, basins, &c. The knife I prefer for opening tolerably superficial abscesses is the ordinary

[1] See paper by anthor, "On the Employment of Belladonna in Surgical Affections," in the *Practitioner*, vol. i., 1868.

double-edged Syme's abscess-knife, which, by its sickle shape, allows a sufficient opening to be rapidly made; but if the matter is very deep (and it is sometimes missed from not going deep enough), I prefer a slender straight bistoury or finger-knife. Of course, the incision should be made in as dependent a position as possible, and always in a direction radiating from the nipple, so as to avoid dividing the lactiferous ducts.

There can be no better treatment than poulticing for a few days after matter has formed in the breast; but over-poulticing—*i. e.*, prolonged for weeks—is strongly to be condemned, since the discharge is thereby kept up, and both the vitality of the part and the strength of the patient are weakened. Cases of abscess of the breast which have been treated domestically from the first not unfrequently come before the surgeon with half a dozen openings, from which flabby granulations protrude, pouring out a considerable quantity of thin, unhealthy pus under the influence of prolonged poulticing. Here the proper treatment is to take off the poultice at once, to support the breast efficiently by strapping or bandaging, to inject the sinuses with some simple stimulating lotion, such as the red lotion (sulphate of zinc, one grain; compound tincture of lavender, one fluidrachm; spirit of rosemary, half a fluidrachm; water, one fluidounce), and to dress each of the openings with water dressing and the above lotion; or, if the parts prove sluggish, with a lotion of nitrate of silver, two grains to the fluidounce. It is seldom necessary to lay open sinuses extensively in the breast, though where there are two small and insufficient openings to a sinus, time may be saved by laying them into one under chloroform. At the same time, attention must be paid to the general health of the patient; hectic symptoms, if present, being checked by sponging the whole body with hot vinegar and water at night, by the administration of the mineral acids in full doses with vegetable tonics; and, subsequently, the health being restored, by the administration of iron, cod-liver oil, and resort to the seaside.

The somewhat rare cases of abscess *behind* the breast are readily recognized by the way in which the whole mamma is thrust forward and made prominent. The matter, which forms rapidly in the connective tissue over the pectorals, has a tendency to gravitate, and thus fluctuation will be always most readily perceived at the lowest part. An early and dependent opening is necessary for the treatment of these cases, and in this situation I have availed myself with advantage of Mr. Hilton's suggestion to introduce a director through a small skin wound, so as to push the point up to the matter, which then finds its way along the groove. A pair of dressing forceps or scissors passed along the director, and expanded so as to open up a passage for the matter, saves all risk of hemorrhage.

The occasional formation of an abscess in the straight tubes around the nipple has been already alluded to, and is readily treated by a timely incision radiating from the nipple. Of a similar character is the chronic dilatation of one of the tubes with milk, due to obstruction of a duct, constituting what is commonly termed a *lacteal tumour*. This is an oblong, semitranslucent swelling, which gives little inconvenience unless it becomes very tense. Occasionally a little steady pressure upon it will remove the obstruction from the mouth of the duct, and thus allow of its evacuation; but more frequently an incision is required so as to allow of the sac granulating up from the bottom.

Suppuration may occur in either the female or the male breast as the result of injury, as I have myself witnessed, and is occasionally seen in the breasts of infants of either sex, as the consequence of foolish squeezing of the part by the nurse, who has noticed the not uncommon existence of a small amount of secretion from the nipple soon after birth. A more puzzling event is the occurrence of a *chronic abscess* in the female breast, either as the consequence of injury, or more frequently in connection with pregnancy terminating in an abortion. The formation of the abscess is very slow, and, the wall being usually thick, it is not easy to detect fluctuation. I have seen such a case mis-

taken for a solid tumour and removed by a very excellent surgeon. In all doubtful cases the exploring trocar should be employed to clear up the nature of the case; and, in fact, as I shall have occasion to mention later, it is always safer to make an exploratory incision into any tumour before removing it, unless the nature of it is perfectly well ascertained beforehand. The treatment of chronic abscess would consist in thorough evacuation by a free incision, with careful after-dressing to insure perfect healing.

I will conclude this lecture by calling your attention briefly to two somewhat uncommon affections of the *skin* of the mamma, of which I happen to have seen examples myself, but which are not necessarily confined to this region.

The first is that curious disease of the sebaceous follicles of the skin known as "molluscum contagiosum," and most frequently seen in children. In the excellent plate of this disease published by the New Sydenham Society, which I now show you, it is drawn from nature on the face and particularly about the eyelids of a child, and also on the breast of the mother. I happen to have met with an almost precisely similar case; and I have no doubt myself as to the communicability of the disease from the child to the mother, and possibly *vice versâ*. The treatment of this form of molluscum is fortunately sufficiently simple; for, with the nails of the finger and thumb, the cyst with the contents of the sebaceous sac can be readily evacuated, and in a few days all trace of the growth will have subsided. The extruded pellet consists of sebaceous matter in a cyst, which is shown in a magnified form in the plate before you.

The other much rarer disease is the true keloid of Addison—morphœa or scleriasis of the skin—of which I am glad to be able to show you an example. The patient, a healthy woman, aged thirty-one, came under my notice two years ago, complaining of great pain about the breast; and I then found the peculiar hardened patch of skin, resembling somewhat a scar, which is characteristic of the disease. Various remedies were tried to relieve the pain, without much benefit; and I had the advantage of consulting the late Mr. Charles Moore upon the case, and he was inclined to regard it as a development of scirrhus. This is not the case, however, for the patient is now much as she was when I first saw her. In Dr. Addison's original paper (republished by the New Sydenham Society) will be found a very similar case reported by Mr. Birkett, in which a patch formed in the axilla and breast, accompanied with a good deal of pain, and in which no treatment gave any permanent relief.—*Lancet*, May 6, 1871.

HOSPITAL NOTES AND GLEANINGS.

Notes on the Medical Treatment of Fibrous Diseases of the Uterus beyond Surgical Interference.—Dr. J. Braxton Hicks, of Guy's Hospital, considers that the medical treatment of fibrous tumours may be divided into—1, the promotion of absorption; 2, the restraint of their growth; 3, the promotion of expulsion; and 4, restraint of the bleeding which they cause. 1. Regarding absorption, Dr. Hicks confesses that he has never seen anything which could encourage one in the expectation of this result. He has given iodine and bromine, and bichloride of mercury, numberless times, without any diminution in the size of the tumour. He thinks those cases where the absorption has been said to have occurred must have been, with few exceptions, erroneously diagnosticated. But 2, with regard to the restraint of the growth of the tumours, he thinks that he has noticed fair results from the employment of iodides and bromides, given, of course, over a considerable period. When the effect of these remedies on the testis and ovary is considered, it is not difficult to understand how these, by checking the impetus to the ovaries, tend to lessen the general engorgement and activity in the sexual organs. To this treatment should be added the recumbent posture during a portion of the day, and the avoidance of all kinds of pressure from external causes. 3. Sometimes much may be done to promote their expulsion by the careful administration of ergot. It may be given in doses of ten grains to half a drachm once

or twice daily, infused in boiling water, and then drank, dregs and all. It may be continued for two or three days every monthly epoch; and it is of much service at this time where severe hemorrhage is present. Dr. Hicks has seen more than twice an intermural fibroid converted into a polypus, and thus rendered capable of being removed. It is well known that polypi have been expelled and dissevered by the action of the uterus alone. Ergot increases this power of the uterine force. Forcing pain is very likely to be caused or increased by this drug; but that is, of course, necessary. 4. The other medical treatment which may be necessary in a case of fibroid tumour of the uterus is to restrain the blood-loss. Recumbent posture, of course, is very essential during the loss. The hæmostatics which Dr. Hicks has found most reliable are gallic acid and ergot. Gallic acid is not of much use under twenty-grain doses two or three times daily, and secale in ten or fifteen grains at the same frequency. He has found that gallic acid, given during the intervals of bleeding, is very useful, coupled with cinchona, quinia, or other good tonics. Where much anæmia is present, he has found it well to give iron-alum, combined with gallic acid, twice a day, during the interval, changing to ergot or full doses of gallic acid at the "period." The mixture is something like ink, but it is clear. Its formula is, one grain of sulphate of iron, ten grains of sulphate of alumina, ten grains of gallic acid, five minims of dilute sulphuric acid, and five minims of chloric ether, in an ounce of peppermint-water. However, if the digestion be feeble, some of the blander kinds of chalybeates may be given, and the astringents at the monthly periods. Sometimes the hemorrhage is so great that one or even two periods are absent; in this case, iron is indicated, but its omission is desirable as soon as the returning colour of the lips shows the improvement of the blood. There is another point which it is desirable not to overlook—namely, the state of the bowels and portal system. Constipation and congestion of the veins of the lower bowel are very apt to increase uterine hemorrhage. The quietude necessary or imposed in this class of cases is very apt to produce this engorgement. Therefore, although strong purgatives are to be avoided, gentle laxatives are of much value. Dr. Hicks cannot say that he has seen much benefit from cannabis Indica, lately recommended in these cases.

Dr. Alfred Meadows, of the Hospital for Women, in regard to the mere drug-treatment of fibrous tumours of the uterus which do not admit of surgical interference, feels very strongly that the sooner we abandon all idea of curing them, or of diminishing them by one hair's breadth, through any supposed absorptive power of medicines administered either by the mouth, by the skin, or by the vagina, all of which he has seen tried again and again, the better, in his opinion, will it be not only for our patient's health and comfort, but for our own credit and reputation as honest men and scientific physicians.

Mr. Spencer Wells objects to the term *fibrous*, as leading to erroneous ideas as to the nature and possible changes in these growths. Whether they are outgrowths from the peritoneal surface of the uterus, or are imbedded in the uterine wall, or project as ingrowths into the uterine cavity, they are simply excessive developments of the unstriped muscular fibres of the uterus, with more or less connective or cellular tissue. They contain little or no fibrous tissue; and though, from their appearance, they may not improperly be termed *fibroid*, they cannot be *fibrous*. Virchow's term *myoma uteri* is the more correct appellation. And this is not a mere word-quibble. Nobody could expect a fibrous tumour to disappear spontaneously; whereas any one who considers for a moment how the uterus grows during pregnancy and shrinks (by involution) in the few weeks after delivery, can easily understand how rapid may be the growth of the muscular fibre of the uterus; how the cellular spaces between the fibres may become filled with serum; how rapidly this may be absorbed; and how the muscular fibres themselves may cease to grow, may become atrophied, or may undergo a process of involution

similar to that which occurs after delivery. Mr. Wells is astonished to find doubts expressed as to the fact of disappearance of these growths. He can only explain these doubts by the juvenility or limited experience of the observers; for he has seen quite a series of cases, where diagnosis has been beyond question, having been confirmed by such men as Farre, West, Priestley, and Oldham, and where there has either been complete disappearance, or such a diminution as to reduce a tumour, burdensome from its size, to insignificant proportions. This is not seen in young women, is rare during active uterine life, but is not at all infrequent after the cessation of the catamenia. Whether medicines have or have not much or any influence over these degenerative or atrophic changes, is quite another question; but Mr. Wells thinks he has seen enough to convince him that they have very considerable influence, provided the remedy be adapted to the case. In those cases where the tumour is elastic, probably more cellular than fibroid, with a good deal of fluid infiltrating the cellular interspaces, varying a good deal in size according to the feelings of the patient, and confirmed by the measurements of the medical man, Mr. Wells thinks that the bichloride of mercury with bark is often followed by remarkable diminution in the size of the growth—sufficiently often to place the remedy and the diminution in a closer relationship than accidental coincidence. Where there is much irregular bleeding, he agrees with Dr. McClintock in regarding chloride of calcium as of great value. He has suggested the calcification of the growth, or of the nutrient arteries, as a possible explanation of its *modus operandi;* but does not attach much importance to the question whether this may or may not be true, if the clinical fact is established that patients who have been losing much blood cease to do so after they have taken the chloride of calcium. The really important matter is to ascertain in what cases it will do good, and when it is useless. Where bleeding has more the character of menorrhagia—excessive loss at the regular menstrual periods, not irregular floodings—Mr. Wells has more confidence in the *vinca major* than in lime, gallic acid, or ergot. He was told of it by Mr. Squire, and prescribes it in the form given in Mr. Squire's version of the *Pharmacopœia*, who now makes a liquid extract from the leaves of the plant—the well-known greater periwinkle of our shrubberies. The plant is so common that we hope much larger experience as to its use may soon be obtained.—*Brit. Med. Journ.*, April 8 and 15, 1871.

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Two Cases of Abscess in the Mastoid Process; Perforation of the Bone.—Case 1. E. F., six years of age, was admitted into Charing-Cross Hospital, under the care of Mr. Barwell, with a history of severe pain in the head, which had the effect of sometimes driving her "half mad," and at other times of producing stupefaction. She had the appearance of having borne a great deal of suffering, and looked ill; the left ear emitted a thick discharge; the corresponding mastoid process, of which the skin was shining and reddened, was slightly swollen and exceedingly tender; the left side of the pharynx was also somewhat reddened and swollen. On the evidence of these symptoms Mr. Barwell decided to pierce the bone from behind the ear. A T-shaped incision was made over the mastoid process, and the two flaps were reflected. On the surface of the bone being then gently probed with the point of the knife, a soft spot was discovered, at which an opening was drilled with a pointed gouge. Through this some thick dark-coloured pus escaped, and some fragments of necrosed bone were removed. Mr. Barwell then scraped the carious portions of the bone until healthy tissue was reached, and plugged the wound with a piece of lint dipped in carbolic-acid lotion.

Two days later the child was free from pain and had lost her suffering appearance. She was ordered ten grains of chlorate of potash three times a day, and was shortly afterwards discharged with instructions to keep the wound open with a plug of lint, and to attend frequently at the hospital. These injunctions she did not, however, obey, and

twelve days after the operation, when she was induced, by a return of the pain in the head, to visit the hospital, the wound was found to have closed. It was reopened with a probe, and its potency was maintained by means of a nail-shaped plug of gentian-root until the thirty-sixth day after the first operation, when every indication for its continued use had disappeared.

In reference to this operation, Mr. Barwell said that abscess in the mastoid process was not an uncommon disease of childhood. It first found vent into the tympanum through the natural opening, but, on account of the insufficiency of this passage, it also made itself a way into the meatus externus. Sometimes the bone would become more and more affected until at length the cerebral surface became involved, and then inflammation and abscess of the brain were liable to follow. Another danger, which the proximity of the lateral sinus would explain, was the supervention of pyæmia. The position of that canal also necessitated the exercise of great caution and gentleness on the part of the operator, lest he should plunge his instrument through the inner table of the skull, more especially as in children the tissues of the mastoid process are soft, and of less comparative depth on account of the non-development of the mastoid cells.

Case 2. The second case is of greater interest, on account of the patient having reached the comparatively mature age of forty-seven, and as the premonitory symptoms were accompanied by profuse epistaxis, for which the patient, Martha B——, was admitted some weeks before the nature of the disease could be clearly made out.

On the occasion of her first admission, the posterior nares were plugged by the house surgeon, Mr. Towt, and large doses of the sesquichloride of iron were administered. The patient was a stout, well-made woman, with a rather puffy face; but no evidence either of kidney or heart disease could be detected. She stated that for some weeks previously she had suffered from occasional epistaxis, and "flying pains" in the head and neck, and that during the night a clear limpid fluid exuded from her left ear. A careful examination of the fauces, nares, and occipital regions threw no light on the cause of her symptoms. The hemorrhage returned twice during her stay in the hospital, and on the forty-third day she was discharged in an improved condition. About six weeks later she was readmitted with intense pain in the left side of the head, and difficulty in swallowing. The skin over the mastoid process was found to be tumid, red, and very tender. The left side of the pharynx was similarly affected. It was decided to operate in this case as in the preceding one, except that an instrument of rather larger size was employed. A large quantity of pus and several small pieces of necrosed bone were liberated. The patient made a rapid and uninterrupted recovery, and left the hospital twenty-four days after the performance of the operation.—*Lancet*, April 29, 1871.

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The Influence of Vibriones on Vesical Discharges.—A middle-aged man came under Mr. Simon's care at St. Thomas's Hospital, suffering from stricture of the urethra, and a purulent catarrhal discharge from the bladder, which rendered his urine peculiarly offensive. The urethra was first dilated in two successive operations by means of Holt's instrument, and then the bladder was daily washed out with a solution of quinia through a double-current catheter. Under this treatment the urine became clear and free from offensive odour in a few days, and the patient, from being obliged to rise as many as fifteen times a night to micturate, became able to hold his water so well that he needs to leave his bed no more than once or twice within the same space.

Referring to this patient, Mr. Simon said that the presence of vibriones in a purulent catarrhal discharge from the bladder coincides with an exceedingly foul and offensive condition of the vesical evacuation, which ceases to exist when the destruction of these bodies is effected. That object is attained most readily by injecting into the bladder a solution of quinia. Mr. Simon makes use of the hospital solution, which contains two

grains to the ounce. He recommends that nitric acid should be the solvent employed, and that a drop of acid should be added in excess of neutralization.—*Lancet*, April 8, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Double Conception.—The following remarkable case is recorded (*Boston Medical and Surgical Journal*, April 13, 1871) by Dr. E. Chenery. A woman, æt. 40, came under his care for inflammation and hypertrophy of the cervix uteri, originating in her first confinement twelve years before. She was successfully treated, and about six months after her cure she became a second time pregnant, and experienced no unusual symptoms till about the fifth month. "At this time, without any known cause, she was taken with pains and bleeding, threatening an abortion. Sedatives and rest were enjoined, resulting in relief for a few days. The symptoms returned, and, being unable to see the patient, another physician was called. Opium and tannin were given. During the night I received another call, when I found that the pains had returned, and the hemorrhage was profuse. She had passed nearly a chamber-vessel full of blood and clots, among which I found a fœtus, with its transparent membranes entire, and altogether of about the size of a common open-face watch. The womb was dilated, and another and much larger fœtus was lying with its head entirely escaped from the os, pushing its unbroken vestments before it. Supposing, of course, that miscarriage of this also must take place, I caught the head between my finger and the wall to bring it into the world, when it slipped from my hold and escaped back into the womb beyond my reach. I had never seen a case where the fœtus survived such a copious flooding, and, to save further trouble, I gave a dose of ergot to finish the delivery. To my great surprise, the womb contracted, the hemorrhage ceased, and the patient recovered."

Dr. C. says that one of the fœtuses "bore the marks of about eight weeks, and the other of twenty. One was expelled with all the appearances of life and freshness up to the time; while the other was retained, and apparently unharmed, notwithstanding the excessive hemorrhage and the extensive separation of its membranes from the womb. With this last the mother was confined at term."

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Hiccough Cured by Chloral.—Dr. P. F. Whitehead (*Medical Record*, April 1, 1871) has recently prescribed for a patient with hiccough, which had continued for thirty-six hours. Various remedies were used with but little good effect, save a temporary cessation by the use of morphia hypodermically. Thirty grains of chloral gave immediate and permanent relief.

The above is confirmatory of the observation of Dr. T. L. Leavitt (*American Journal of the Medical Sciences*, April, 1871, page 363) on the power of chloral in controlling this, oftentimes distressing, affection.

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American Medical Association.—The twenty-second annual meeting of the Association was held at San Francisco, May 2d, 3d, 4th, and 5th. Dr. Alfred Stillé, of Philadelphia, presided. The Committee on Prize Essays reported in favour of awarding the prizes as follows: First prize, to E. R. Taylor, M.D., of California, for essay upon the "Chemical Constitution of the Bile." Second prize, to Benjamin Howard, M.D., of New York, for essay upon "The Direct Method of Artificial Respiration for the Treatment of Persons apparently Dead from Suffocation, from Drowning, or from other Causes." The following officers were elected for the ensuing year: President, D. W. Yandell, M.D., of Kentucky; Vice-Presidents, Thos. M. Logan, M.D., of California, C. L. Ives, M.D., of Connecticut, R. M. Mitchell, M.D., of Alabama, J. K. Bartlett, M.D., of Wisconsin; Assistant Secretary, D. Murray Cheston, M.D., of Pennsylvania; Librarian, F. A. Ashford, M.D., of D. C.; Treasurer, Caspar Wister, M.D., of Pennsylvania. The next annual meeting will be held in Philadelphia, on the first Tuesday in May, 1872.

Iowa State Medical Society.—The nineteenth annual meeting of the Iowa State Medical Society was held in Des Moines on the 19th and 20th of April, 1871. The attendance from all parts of the State was unusually large, and papers and reports presented, and the discussions were of more than ordinary interest. The greatest harmony and good-will prevailed throughout the session.

The following persons were unanimously elected officers for the ensuing year: President, Dr. A. G. Field, of Des Moines; Vice-President, Dr. J. M. Robertson, of Muscatine; Recording Secretary, Dr. Geo. P. Hanawalt, of Des Moines; Corresponding Secretary, Dr. J. F. Ely, of Cedar Rapids; and Treasurer, Dr. J. W. Gustine.

The next meeting of the Society will be held in Des Moines, the first Wednesday of May, 1872.

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University of Pennsylvania.—D. Hayes Agnew, M.D., Professor of Clinical and Demonstrative Surgery in this institution, has been also appointed to the chair of Principles and Practice of Surgery, rendered vacant by the resignation of Dr. Henry H. Smith.

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College of Physicians of Philadelphia; Mütter Lectureship.—Dr. J. Solis Cohen has been appointed to deliver the annual course of lectures provided for by the bequest of the late Dr. Mütter. The subject will be the Surgical Affections of the Air-Passages.

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The Warren Prize.—It is announced that this prize has been awarded by the staff of the Massachusetts General Hospital to Dr. Horatio C. Wood, of Philadelphia, for his essay on Nitrite of Amyl.

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Atlanta Medical and Surgical Journal.—This journal, the publication of which had been discontinued for the past three years, has been again revived, and the first No. of the ninth volume is on our table. We take pleasure in restoring it to our exchange list. It is edited by W. F. Westmoreland, M.D., Prof. of Surgery, and J. C. Westmoreland, M.D., Prof. of Materia Medica in Atlanta Medical College.

Monstrosity.—The Ischiopage monster described in the number of the *American Journal of the Medical Sciences* for January last, is still living, having attained the age of nearly eight months, and is now in Philadelphia. It was recently exhibited to the medical class at the University of Pennsylvania, and was the subject of an interesting clinical lecture delivered by Dr. Wm. Goodell.

FOREIGN INTELLIGENCE.

Therapeutic Value of Iodine in the Treatment of Syphilis.—Affections of the nervous system, due to syphilis, are always, according to the experience of Dr. Buzzard of the National Hospital for the Paralyzed and Epileptic, either connected with its tertiary stage or ascribable to hereditary taint. And when the patient's history is investigated, it is, in the first of these cases, more common, on the whole, to find that no secondary symptoms were observed than that these have been well marked. Not only is this the case with hospital patients, in whom an error of observation is of course probable, but also with persons occupying a superior position in life, who would have been highly sensitive to the occurrence of the skin eruption, iritis, loss of hair, or sore throat, if they had been affected by such symptoms. As regards the previous administration of mercury for the primary affection, Dr. Buzzard finds that this, more often than not, has been carried to the point of salivation. The nervous affections belonging to the tertiary stage are very numerous, and their diagnosis is frequently very obscure, but for our present purpose they may be briefly enumerated as follows: Affections of the coverings of the brain, with or without lesion of the cerebral substance, and giving rise to epileptiform attacks, hemicrania, nausea, vertigo, or hemiplegia; optic neuritis; general paralysis and dementia; neuralgia; paraplegia; paralysis of one or more of the cranial nerves or of spinal nerves; progressive locomotor ataxy. It is not common to meet with well-marked tertiary symptoms affecting remote structures in cases of nervous affection due to syphilis. Occa-

sionally, no doubt, patches of psoriasis may be observed, or serpiginous ulcers present themselves and aid the diagnosis, or a cellular node is to be found on one of the lower extremities, the cranium, or the sternum; but as a general rule such evidences are wanting. And so also in regard to the general aspect of the patient, every variety may exist, from the appearance of good health to a state of extreme cachectic debility. It is perhaps in the latter class of cases that iodine treatment is most efficacious. In all cases there is a great tendency to relapse.

In all cases of nervous affection due to syphilis, Dr. Buzzard is in the habit of employing the iodide of potassium, at least in the commencement of the treatment. He has found no reason to prefer the salt of any other base; and believes that any good to be obtained by the use of iodine may be most conveniently arrived at by the employment of this salt. Its effects, however, are subject to remarkable varieties. Acting like a charm in a number of cases, it is very disappointing in others which, nevertheless, present good grounds for the belief that they are of a syphilitic character. The duration of the symptoms before specific treatment is commenced is probably the most important element in this variation of results. Where the patient is seen early, and the diagnosis of syphilis rapidly acted upon, it would seem that the neoplasm is removed from the connective tissue in which it is deposited ere there has been time for the nerve-structure proper to have become seriously damaged. However severe may be the symptoms—complete paralysis of one or more cranial nerves, the occurrence of violent epileptiform seizures, or more or less complete paraplegia—if these depend, as they frequently do in the earliest period, upon simple pressure exerted by the effused gummatous products, the absorption of these, under the influence of iodide of potassium, sweeps away the grave symptoms with remarkable celerity. But where, owing very often to want of recognition of the cause, valuable time has been lost, softening of nerve-structure has taken place from the pressure of gummata, or sometimes from inflammation and consequent obliteration of arteries. Under such circumstances the use of iodide is but limited. A certain amount of improvement will take place, and then the symptoms will remain stationary in spite of the continued employment of the drug. But even in such instances the continued use of the iodide will often be of great benefit; for it appears able to prevent the extension of disease to other and possibly more important parts of the encephalon or spinal cord.

Various as are the lesions of the nervous system resulting from syphilis—pain, convulsion, paralysis of motion or of sensation, and muscular atrophy—there is not, Dr. Buzzard thinks, sufficient evidence as yet to show that one of these symptoms is *primâ facie* more likely to be beneficially influenced by iodide than another. In all the causative disease has to be treated, not the symptoms. Let there be a reasonable probability that any of these phenomena owe their origin to the presence of a syphilitic taint, and, if time has not elapsed for irreparable damage to be sustained, the use of the iodide is indicated, and will certainly be of the greatest service. And it seems likely that the explanation of this universal utility depends upon the fact that, at least in the first instance, the tissue affected in these various conditions is the same. It is the connective tissue in which the pathological changes occur, and wherever this may be situated, the disease in it will be amenable to the same treatment. Early diagnosis is everything in these affections. A patient may present himself suffering from very slight seizures which he calls "faints"—indescribable sensations which are scarcely, if at all, noticed by an observer. These are often of syphilitic origin; and, if their cause is mistaken, and a routine treatment (of bromide of potassium, for example) be adopted, they will rapidly increase in severity till violent epileptiform seizures take place, and possibly a hemiplegic condition supervenes. But a few grains of iodide of potassium administered daily will clear these "faints" away as by a charm, and, judiciously continued, will obviate the tendency to further mis-

chief. The same thing occurs with the numerous cases of paralysis of one or more cranial nerves, that are so frequently of syphilitic origin.

As regards the mode of administration, Dr. Buzzard is ordinarily accustomed to commence with a dose of ten grains of the iodide, taken in water three times daily, and increased, if it appear necessary, at intervals of a few days, to fifteen, twenty, twenty-five, thirty, forty, or sixty grains. Upon the symptoms disappearing, he does not altogether suspend the use of the drug, but continues it in a moderate dose for weeks, sometimes months, and occasionally for years, withholding it now and then for a few weeks, and administering mineral acids, or iron, if anæmic symptoms be present. It is worth remarking that intelligent patients who have taken much iodide learn to judge from their sensations that a return to it is advisable, when they have discontinued it for some time. There are, doubtless, exceptional cases in which the iodide of potassium causes distress; but as a general rule it may be taken, with occasional intermissions, for months or even for years without injury or discomfort. Dr. Buzzard is not disposed to think that the addition of mercury is of service in tertiary syphilis affecting the nervous system; but he considers it useful in the case of children suffering from hereditary taint in whom nervous phenomena are present. His experience does not show him that any advantage is to be gained, as a general rule, by the addition of ammonia or of bitter tinctures to the iodide, which he prefers administering alone in a little water midway between meals. In certain cases, however, of continued epileptiform seizures, having a syphilitic origin, he finds that the combination of the bromide of potassium, in twenty- or thirty-grain doses, with five grains of iodide, two or three times a day, is attended with advantage.—*Lancet*, March 11, 1871.

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Essence of Turpentine in Parasitic Disease of the Head.—Dr. Erlach, of Berne, remarks (*Giorn. Ital. delle Mal. Venere*, Nov. 1870) that in order to destroy parasites, which are the cause of several diseases of the hairy scalp, Küchenmeister recommended the application of alcohol, which retards the development of spores and mushrooms. Experience has shown, however, that the action of alcohol does not extend to the fungi that are found in the hair follicles. Tincture of iodine acts better than alcohol; nevertheless, the treatment by this remedy does not last more than three months, even in the most favourable cases. He has found, however, that the application of essence of turpentine by means of a brush is more certain and rapid than all other methods of treatment. He believes he has thus cured a case of herpes tonsurans in seven weeks; several cases of mentagra in a week.—*Practitioner*, April, 1871.

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Solution of Ammonia in Delirium Tremens.—The efficacy of ammonia in drunkenness naturally suggests its employment in delirium tremens, which is only a prolonged attack of drunkenness, and it has recently been employed with good effects in heroic doses by Dr. Gouamier. (*Gaz. Med. Lomb. et L'Imparziale*, Jan. 1, 1871.) One of his cases was a robust man, forty-five years of age, whose limbs were in a constant state of agitation, with sleeplessness and a sub-delirious state. Dr. Gouamier prescribed an ounce of strong infusion of valerian root, and thirty drops of solution of ammonia, edulcorated with simple syrup, to be taken every two hours; after five doses, sleep supervened, and the agitation of the limbs was effectually cured.—*Practitioner*, March, 1871.

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Sulphate of Quinia in Obstetric Practice.—Dr. Monteverdi considers (*Nuova Lig. Med.*, No. 4, 1870) that he has discovered new properties in this salt. According to the author, it acts not only as a general tonic, but also directly on the uterus, causing contractions which lead to the expulsion of fœtus and placenta. In this respect, the quinia is thought greatly superior to ergot, as it does not, like the latter, act injuriously on the fœtus; nor is this all, as the quinia may be used in cases of narrow pelvis, undilated os uteri, and before the escape of the amniotic fluid. It may also be given in the hemor-

rhage occurring in pregnant women, in amenorrhœa depending on a torpid state of the uterus, and puerperal fever.—*Lancet*, April 29, 1871.

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Puncture in Anasarca.—Dr. Handfield Jones communicated a paper on this subject to the Clinical Society. He advocated making a single puncture in the calf of each leg with a trocar, and, after withdrawing the stilettes, leaving the canules open for several hours, to allow the fluid to drain away. In this manner he succeeded in the first operation in drawing off sixty measured ounces of fluid from the right leg, but only ten from the left, in consequence, he supposed, of the canula not lying properly in the subcutaneous cellular tissue. In a second operation on the same man, three days afterwards, he drew off one hundred and twenty ounces of fluid, besides a great deal which ran from the puncture for several days afterwards, sufficient to saturate three blankets. For the performance of the operation, the man was placed in a sitting posture, and this he considered important, as it facilitated the draining away of the fluid.—*Practitioner*, April, 1871.

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Resection of the Elbow-Joint.—A case which showed how great the amount of motion attainable after resection of the elbow-joint may be, was exhibited a few evenings since to the Medical Society of London by Mr. J. D. Hill. It was that of a man, aged thirty-two, who had sustained a compound comminuted fracture of the olecranon, about four years ago. An attempt to save the joint failing, the operation of resection was practised a month after the receipt of the injury, and the case rapidly recovered, with good motion at the end of three months. The man has now complete control over the brachial muscles, the power of flexion and extension being very good, and supination and pronation nearly equal to those of the other limb. He can carry a bucket of water, use a saw or hammer, and write a good hand. In the operation a long straight incision was made at the back of the joint; the attachments of the brachialis anticus and of the biceps were carefully preserved; a chain saw was used to cut from within outwards, to avoid disturbance of the soft parts; and the limb, after operation, was placed upon interrupted rectangular splints, so that the ends of the bones were kept apart during the healing process. The case shows how readily free movement can be obtained when the muscles can be brought into action soon after operation, before they begin to waste, and whilst the new interosseous textures are yielding.—*Lancet*, April 22, 1871.

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Ivory Exostosis of the Sclerotic.—Mr. W. Spencer Watson exhibited to the Pathological Society of London (Feb. 7, 1871) a small ivory exostosis, which he had removed from the upper and outer quadrant of the left eyeball, where it lay attached by a cartilaginous base to the sclerotic, midway between the external and superior recti. No similar case is on record, but it is possible that some of the recorded instances of ivory exostosis of the orbit of large size may have originated in small growths similar to the one exhibited.—*Med. Times and Gaz.*, Feb. 18, 1871.

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Smallpox.—The number deaths in London for the weeks ending March 4, 11, 18, and 25, were respectively as follows, 213 194, 185, and 205, and for the weeks ending April 1, 8, 15, 22, and 29, were respectively 192, 214, 265, 276, and 261. These statistics show a slight diminution in the mortality of the epidemic in March, with a large increase in April. Not only has smallpox been making considerable advances in London in April, but it is stated that the character of the cases has been assuming greater virulence.

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Death from Chloroform.—At the Swansea Hospital, a few days ago, a clog-maker, named Barrett, died under the influence of chloroform. Three weeks ago he fractured his leg, and, amputation being considered necessary, the preparations were made, with his consent. Before the operation commenced, and while inhaling the chloroform, he died.—*Lancet*, April 22, 1871.

Preservation of Pepsine.—Dr. Lionel Beale writes to *Nature* to the effect that the means hitherto adopted for preparing pepsine for medical purposes are clumsy and inefficient. Dr. Beale, however, claims one exception, a process described by himself in 1858. It simply consists in quickly drying the mucus expressed from the pig's stomach glands upon glass plates. The dried mucus is then powdered and kept in stoppered bottles. It retains its properties for years. Eight-tenths of a grain will dissolve *one hundred grains* of coagulated white of egg. From this powder is easily prepared by solution in distilled water a perfectly clear and colourless digestive fluid of great activity, which *can be readily filtered.—Med. Press and Circ.*, March 1, 1871.

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Lifelike in Death.—Rossbach, in a late number of Virchow's *Archiv* (Band 51), has given an interesting account of numerous cases of sudden death on the fields of Beaumont and Sedan, in which the bodies of those killed retained the position and the expression of face present just before death. In one case, a group of six French soldiers were killed by the explosion of a single shell as they were breakfasting in a slight hollow. The shell had struck one of them sitting in the middle full in the back, where it was partly lodged; the fragments had torn away his thighs and buttocks, and killed his comrades. From one of them the skull was carried off, while the face still retained the expression of laughter at the joke of a companion. The next one to him still held, delicately raised to his lips, between the forefinger and thumb, a tin cup, from which he was about to drink, when the explosion had taken off the whole of the upper part of the face and head. The close manner in which they were seated together had prevented the bodies from falling after the lapse of twenty-four hours. In another case, a soldier, shot through the breast, lay half reclining on one side, with the photograph of his wife or lover held up straight before him. Rossbach cannot admit that in such cases the nervous centres must necessarily be injured, nor that death must have been instantaneous. Rigor mortis must have set in between the last moment of life and the first of death.—*Lancet*, April 22, 1871.

Dr. J. H. Brinton, in an interesting article on this subject, published in the *American Journal of the Medical Sciences* for January 1870, page 87, relates a number of similar cases which were observed during the late war in this country.

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Pangenesis.—Mr. Galton, F.R.S., read a paper last week at the Royal Society, describing experiments on pangenesis by breeding from rabbits of a pure variety, into whose circulation blood taken from other varieties had previously been largely transfused. By an ingenious device the blood from one rabbit was made to flow freely from carotid to carotid into the circulation of the other of a different variety, for nearly half an hour. The results of breeding showed no variations of character in the offspring. This he held to contradict the theory of pangenesis, which asserts that the elements of simple reproduction, of reversion, growth, repair of injuries, and other allied functions, reside in the blood, as gemmules, which live and multiply there, and that the solid framework of the body is little more than a case which incloses them, built up by the development of some of their number, and exercising no further influence on them, than suffices to account for the minute effects of use and disuse of parts and of acquired mental habits being transmitted hereditarily. — *British Medical Journal*, April 8, 1871.

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Obituary Record.—It is with profound regret that we record the death of Vienna's great clinical teacher. Oppolzer, Professor of Special Pathology and Therapeutics in the University of Vienna, died on the 16th of April, of typhus fever, after an illness of a few weeks' duration, aged 63. Thus the two great teachers, who have for so many years maintained the fame of the Vienna school, have, in quick succession, passed from the field of their labours—Skoda into retirement, and Oppolzer to "that undiscovered country, from whose bourn no traveller returns."

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*** As "Roberts on Urinary and Renal Diseases" is out of print for the present, the above work will be found a convenient substitute.

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GUERSANT ON SURGICAL DISEASES OF INFANTS, ETC., 16 PAGES.

CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Digital Examination of the Uterus.

By GRAILY HEWITT, M.D., Professor of Midwifery in University College, and Obstetric Physician to University College Hospital.

GENTLEMEN: I propose to speak to-day on a subject introductory to the study of the diseases of women—namely, the methods of examination which assist us in obtaining information with respect to those diseases. The difficulties in practice are not so much difficulties in regard to treatment as to diagnosis. Moreover, mistakes in practice are more frequently due to errors in diagnosis than to any other cause. The knowledge of the physical condition of the generative organs was formerly a matter very much of conjecture. Physical examination was only carried to a slight extent. True, ages past, some old physicians, such as Actius, as was not long since pointed out in one of the medical journals, had been acquainted to a certain extent with the physical alterations of the uterus, which must have been derived from a careful examination by means of the finger. It is a fact, however, that until comparatively recent times the investigation of the physical condition of the generative organs was carried to a very slight extent.

Within the past thirty years much attention has, however, been given to this subject. For some time the speculum was the instrument almost exclusively used in obtaining information as to the physical condition of the uterus. This method of investigation has been followed, in too many cases, to the exclusion of all

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other methods of examination. One cannot, therefore, be surprised at finding that in many instances very remarkable physical alterations of the uterus remained quite undetected, since the examination was confined to a visual inspection of the os uteri. It is, however, from digital examination of the uterus that we are able to learn most regarding the condition of the uterus. This is a point I am most anxious to impress upon you; and I now desire to explain to you how this examination is to be made, and what are the results to be expected from it. I was exceedingly pleased to find in a work recently published by M. Courty, of Montpellier, that the extreme importance of the digital examination of the uterus is so fully recognized. Unquestionably the speculum, and above and beyond that the sound, give completeness and exactness to the investigation in particular cases; but still the digital method stands first, and you will do well to recognize this as the primary one.

By means of the finger educated to the proper degree, you can become acquainted with the size and position of the uterus, the state of the vaginal canal, with the condition of the organs lying in the immediate vicinity of the uterus, the ovaries; with the presence of a tumour lying in the pelvis in the same situation, and affecting the uterus. You can make this examination by the vagina, or you can make it by the rectum. Another method consists in a sort of double examination, one finger being inserted into the vagina, and one or two fingers being placed over the symphysis pubis. When the patient is in a favourable position, you can get thus most important information. So also a double examination from the rectum and over the pubes can be made by placing one finger in the rectum and two over the pubes. You endeavour to bring the two together, and if the patient is not very stout or fat, you can do this in such a perfect manner as to make it absolutely certain, for instance, that there is no uterus in a case in which that organ is congenitally absent. Thus also you can determine the shape of the top of the uterus. In fact, there seems to be hardly any limit to the information that can be gained from it under tolerably favourable circumstances. Much, however, depends on the position in which the patient is placed, and by far the best position for such double examination is lying on the back, not on the side, with the knees drawn up, and the observer standing at the patient's right hand. The first or second finger of the right hand is then passed in as far as possible; then two fingers of the left hand are placed over the pubes, and pushed inwards and downwards into the pelvis. In this way the two fingers can be brought into close proximity, the abdominal walls being in this position completely relaxed.

I will next describe the digital examination of the vagina only. A proper position is very essential; and the only good one is for the patient to lie on the couch on her left side, with the hips close to the edge, and the knees drawn well up. It is quite impossible to make a satisfactory examination with the patient lying in the middle of a soft bed.

The examination is usually conducted by means of the forefinger of the right hand. To arrive at the aperture of the vagina, place the left hand upon the great trochanter of the patient, and immediately under that you will find the vulva. Remember the distinction between the vulva and the vagina. The former is nearly an inch in depth; and after passing on for that distance, the finger comes to the position of the hymen, the beginning of the vagina proper. If no impediment is created by the existence of the hymen, the finger of course passes inwards as far as the vagina extends; and the normal length of the vagina, including the part belonging to the vulva, is represented pretty exactly by the length of the forefinger, which has to pass in almost as far as it can be inserted before its tip reaches the cul-de-sac behind the os uteri.

Thus the first thing that is determined by this examination is the length of the vagina. That is determined at once. Next comes the condition of the uterus; and the facts relating to this must be set down under several heads.

The first point is the condition of the os uteri. Normally, in the woman who has

not borne children, the finger finds merely a small aperture. In women who have had children the aperture is generally larger, it may even be so large as to admit one or two fingers.

Next determine the length and shape of the cervix, and recollect that it really occupies nearly one-half of the length of the uterus. The part which can be felt by the finger in the vagina is, however, only a small portion of the cervix—the "vaginal part," as it is called; the greater part of the neck is above that. You have to determine the length of this vaginal portion. In women who have not borne children this is not more than half or three-quarters of an inch. It may be much longer, or it may be shorter, and the latter point becomes very important with reference to the diagnosis of pregnancy. The cervix is not really shortened in that condition, but it is drawn up out of the vagina so as to appear shorter.

Next the density of the vaginal part of the cervix has to be investigated. There is a considerable softness about it normally, and yet it is pretty firm. In pregnancy it becomes very soft, and in the latter part of pregnancy it becomes as soft as velvet, so that towards the end you have a difficulty in making out that there is an os uteri at all.

The symmetry of the os uteri should next engage your attention. Is it symmetrical in form? Is it symmetrical as regards density? Nodulation or cicatrization is an important sign. In cancer, for instance, there is a complete loss of symmetry both as regards form and density; it is irregular in outline, nodulated often, harder than natural, and the increased density is always greater on one side than on the other.

If you are a beginner you will find that this part of the examination will occupy you at least several minutes. The more practice you have the more rapidly will you be able to determine these several points.

After thus investigating the condition of the os, you may next proceed to examine the neighbourhood of the uterus. This may conveniently be regarded under four divisions: (1) that in front of the uterus; (2) that behind it; and (3, 4) those on each side of it.

Commencing with the examination of the anterior region, the finger is pushed forwards and upwards in front of the neck. It displaces the vaginal wall before it, and can thus be made to rise to a considerable distance in the pelvis between the uterus and the bladder. You will readily understand that, if the uterus is bent forwards unduly, the finger will thus come upon it and touch it. So, also, if there is a tumour in front of the uterus, the finger will come upon it. Thus this examination will inform you of the presence or absence of a tumour there, or of anteflexion or anteversion of the uterus. Sometimes anteflexion will escape notice thus. The finger, being pushed forcibly up in front of the uterus, causes the organ, as a whole, to turn on its axis backwards, and you may fail to find the tumour because it retreats before the finger. The longer the disease has existed the more likely is this to occur, since after lapse of time the uterus gets rigid and fixed in its abnormal shape. This examination in front of the uterus will enable you to eliminate pregnancy. If a patient has arrived at the third month of pregnancy, you will certainly be able to detect the enlargement of the uterus; while if you can detect no tumour in front of the cervix you may be pretty sure that pregnancy does not exist. Pelvic tumours of various kinds are liable to be met with there. An ovarian tumour may be felt there. A tumour growing out of the uterus itself may be found there. Peri-uterine hæmatocele, consisting of an effusion of blood, may be situated in front of the uterus, and cause a hard and rather firm tumour in this position. In pelvic abscess and cellulitis there is an induration in the pelvis which may also be situated in this locality.

The neighbourhood behind the uterus is equally important with that in front of it; and its examination ought never to be neglected. When the uterus is in a proper position, the finger, passed up behind the cervix, is unable to explore the uterus higher than a point just above the junction of the vaginal wall and the cervix; and nothing can be felt beyond

that point. But we often do find a tumour in that situation. Its most common cause is retroflexion of the uterus; and then the finger comes upon the body of the uterus behind its neck. In all cases of retroflexion, except those in which the amount is very slight indeed, you will find a tumour there. Certainly, in ninety-nine cases out of a hundred you will be able to detect it. I have frequently known marked retroflexion to be missed solely from the practitioner neglecting to examine the part behind the neck, and confining the investigation to the condition of the os itself. Finding a tumour there, you have next to make out its shape; and the most important thing to ascertain is whether the tumour is symmetrical and in the middle line. The retroflexed fundus is usually, as might be expected, symmetrical, and generally nearly in the middle line. But the tumour may be due to other conditions: one of the ovaries may be displaced, and may lie near the middle line behind the uterus. It is not common; but the ovary may be found there, enlarged and painful. You would separate it from the uterus by making out that it was not continuous with the cervix. The point of the finger is made to travel slowly from one point to another; and, if it be an ovary, you find a break between the two. A fibroid tumour growing from the back of the uterus is not very rarely met with in this same position, which may be of any size, and may simulate very closely retroflexion of the uterus. The diagnosis between the two is made with the greatest possible ease by means of the sound. Sometimes a fibroid tumour is associated with retroflexion, and is, indeed, its cause, pulling the uterus back. Another tumour often met with there, is that caused by pelvic cellulitis. This is usually found to one side; it is hard, dense, and resistant in the chronic stage, and the parts are evidently all matted together. It is sometimes difficult to distinguish this tumour from one that consists of a fibroid tumour alone. Peri-uterine hæmatocele is more common in that situation than in any other.

By examining the lateral aspects of the uterus, you become acquainted with the condition of matters in the broad ligaments—the space which intervenes between the two surfaces of the peritoneum which are reflected over the Fallopian tubes, and inclose a dense mass of cellular tissue and an immense quantity of vessels, veins, arteries, and lymphatics. It is in this situation that inflammation so frequently occurs. If you suspected that a patient had pelvic cellulitis, you would, as a rule, expect to find the swelling on one side or other of the uterus. Tumours do not so often grow from the sides of the uterus as from the front and back, or at all events are not so obvious on a vaginal examination. Effusions of blood may also occur at the sides of the uterus. Sometimes the uterus is turned over to one side, giving rise to lateral version; and this is very commonly combined with anteversion. In retroversion it is common to find the uterus a little to one side of the middle line, but not so much as in anteversion.

Having thus examined the os uteri and the region round it on all sides, by means of the double examination I have before referred to, you may extend this, and render some things certain which before were uncertain.—*Lancet*, May 13, 1871.

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Clinical Remarks on the Treatment of Orchitis — In a clinical lecture on this subject, Mr. JONATHAN HUTCHINSON remarks (*Medical Times and Gazette*, April 22, 1871) that in that form of orchitis, in which the epididymis, body of the testis itself, the tunica vaginalis, and the cellular tissue of the scrotum, are all involved, gonorrhœa is the most common cause. In these cases the effusion is usually serum only, and a speedy and complete cure by absorption may be expected; but in exceptional instances suppuration may occur in the cavity of the tunica vaginalis, and, in others still more exceptional, in the body of the testis itself. Gonorrhœal orchitis almost always subsides spontaneously, and without any permanent damage to the gland. All that is necessary is to keep the patient in bed, to purge him freely, and apply ice to the part. Now and then, however, the severity of the inflammation may be such as to

threaten abscess, or even to cause gangrene. When the pain is intense, and persists, in spite of the use of ice, Mr. Hutchinson believes that the practice of making incisions is not only safe, but very valuable. Some surgeons, he observes, are in the habit, even in ordinary cases of gonorrhœal orchitis, of seeking to relieve tension by making one or more punctures into the tunica vaginalis, or even into the testis itself. He believes that it may be accepted as the result of their experience that such punctures seldom do any harm; to most surgeons, however, they scarcely appear to be necessary. In recommending incisions, Mr. Hutchinson states he is speaking rather of the exceptional states in which abscess is threatened; and, in looking back upon his own experience, he is certainly inclined to regret that in several cases he did not make incisions earlier. A free incision into the tunica vaginalis leads to no ill consequence whatever, and if it happens that pus is let out the relief is immense. A free incision through the tunica albuginea into the testis itself does not lead to gangrene of the testis, nor always even to fungous protrusion. When the testis is swollen, it appears to relieve pain much with the same certainty that iridectomy does the pain of acute glaucoma, and Mr. Hutchinson's impression is that it is likely in critical cases to diminish the danger of gangrene on the one hand, and of consecutive atrophy on the other.—*The Practitioner*, June, 1871.

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Clinical Remarks on the Treatment of Hæmoptysis.—Dr. Waters, in a clinical lecture on this subject, stated (*Brit. Med. Journ.*, March 11, 1871) that when hæmoptysis occurs during the progress of a case of phthisis, no special treatment need be directed to it; should it be, however, at all severe, rest should be enjoined, and no risk run by which an inflammatory attack might be brought on. In regard to the various measures that are usually resorted to, he considers the best remedy to be used is gallic acid, as being the safest, the most rapid, and the most effectual. It should be given in full doses of not less than 10 grains every hour, or every two, three, or four hours, according to the severity of the case. It is readily taken by patients, it rarely disagrees with the stomach, and is well borne by delicate persons. It rapidly finds its way into the urine and is excreted. Acetate of lead, especially when combined with opium, is often of great service. He usually gives it in the form of pill, in two or three grain doses, every two, three, or four hours, but it should not be too long continued on account of its constipating effects. Sulphuric acid is a good remedy in slight cases of hæmoptysis, and it may be combined with other substances, as quinia and iron, which are given for the general treatment of the disease. It should be given in doses of from 10 to 30 minims. Dr. Waters' experience of the use of ergot of rye in pulmonary hemorrhage is not very favourable. In severe cases of hæmoptysis he always applies ice to the chest; it should be included in a bag, and not allowed to remain so long as to produce a chill. In regard to digitalis, as far as his experience goes, he is unable to recommend it as a trustworthy remedy in hæmoptysis. He occasionally prescribes dry cupping, but never fails to give styptics internally at the same time. He gives a caution against the indiscriminate administration of purgatives. Turpentine he considers to be less valuable in hemorrhage from the lungs than in hemorrhage from the bowels. The room should be kept cool and well ventilated; the food should consist of iced beef-tea and milk, and small pieces of ice given to the patient to suck.—*The Practitioner*, May, 1871.

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Diagnosis of Recent Endocarditis.—Prof. Skoda observed (*Lancet*, June 3, 1871), in the course of some clinical remarks at the Vienna Hospital, with regard to a case of second attack of acute rheumatism, with a systolic murmur at the apex of the heart, that, though the mitral insufficience here present was a proof that endocarditis *had* existed, the question one should always consider, if a patient come under observation with an intra-cardial murmur and rheumatism side by side, is: "Is this murmur due to old or to recent endocarditis?" Where the history fails to help us,

we may be aided by remembering the following points: In a recent endocarditis the spleen will probably be plugged (infarcted) with fibrinous deposit from the valves, and therefore *enlarged*. Similar infarction of the kidneys will give rise to the presence of blood in the urine. Pains in the cardiac region, and irregularity and palpitations of the heart, if they exist, point to a recent endocarditis; but they depend more on the fever present than on the endocarditis *per se*. The most certain proof of fresh endocarditis is a gradual increase of dilatation of the heart during the course of the rheumatic attack, especially if followed by palpitations and dyspnœa.

HOSPITAL NOTES AND GLEANINGS.

Operation for the Cure of Prolapsus Uteri.—Dr. Graily Hewitt's operation for the cure of prolapsus uteri consists in removing from the perineal end of the posterior wall of the vagina a triangular portion of mucous membrane, of which the apex is towards the uterus, and the base at the posterior commissure of the vulva. In the present instance, an operation performed two months previously had succeeded so far as regarded the vaginal mucous membrane, but, union having failed to take place between the edges of the base of the triangular wound, the constriction of the vaginal orifice, which was the main object in view, had not been effected. Dr. Hewitt pared the edges of the posterior half of the orifice, and brought them together by means of two deep interrupted sutures of strong metal wire, and three superficial sutures of finer wire inserted within the deep ones. The deep sutures were secured by means of a small apparatus which Dr. Hewitt calls a "bead." It is made of ebonite, is gourd-shaped, and consists of a body and an expanding neck, of which the former is as large as a full-sized pea. When the suture is inserted, a bead is strung on at either end, with the neck outwards; and while it is pressed against the labium with one hand with the proper amount of force, it is fixed in position by winding round its neck, with the other, the projecting extremity of the wire suture. Dr. Graily Hewitt claims for the beads that, their action being more defined and local than that of portions of bougie, they have not the same tendency to maintain, in the included lips of the wound, a state of congestion which is unfavourable to healing, and has, in some instances, produced sloughing.—*Lancet*, April 29, 1871.

Case of Uterine Hæmatocele.—H. C., aged 39, is a widow, and has had no children. She was admitted to Ward 16, under Dr. Matthews Duncan's care, on February 16, complaining of pain and swelling in the lower part of her belly, and of pain at the base of the sacrum. About a fortnight before admission, after being exposed to the influence of cold and damp during menstruation, she caught a severe cold, which confined her to bed for some days. Her last monthly period began a fortnight ago; it lasted for three days only, her previous periods ending after an illness of a week's duration. On the day following this abrupt disappearance of the last menstrual flow, she noticed a swelling in her belly at its lower part, which was hard and painful. The size and hardness of, and the degree of pain felt in the tumour by the patient were increased next day. Her monthly periods had been previously regular.

On inspection, the belly is observed to be somewhat prominent, but presenting to the hand a natural feeling, except on the right side inferiorly, where a mass of hardness is felt, which rises as high as half way to the umbilicus. There is no particular tenderness or sensitiveness on touching this, and there is resonance everywhere over it. On examination per vaginam, the cervix is found to be nearly in its natural situation, uterus fixed. The pelvis is not occupied by the tumour, but in the plane of the brim there is felt fulness, and at the right side hardness.

The tumour above described gradually diminished in size, and on an examination being made three weeks after admission, a trace of it only could be detected.

Remarks.—It is almost inconceivable that a disease like the one at present under consideration, which must have existed as long as woman herself, should

have been recognized and described for the first time within the last twenty years. Long after its description, however, ignorance as to the nature of uterine hæmatocele prevailed in this country, and it is only recently that it has become at all widely known. One might ask—What did our predecessors make of such cases? They were, in all likelihood, mistaken by them for ovarian dropsies, fibroids of the uterus, etc., and their subsequent rapid absorption and disappearance were probably attributed to the potent deobstruent qualities of certain drugs, or cited as instances of the spontaneous cure of these diseases. An intimate connection between menstruation and the advent of a uterine hæmatocele is, in many cases, to be observed. On studying the history of the case before us, this point is well illustrated. The woman C., instead of remaining poorly for a week, as was her wont, menstruated for three days only, and it was, she tells us, on the day after the cessation of her menses that she first noticed the swelling in her belly. This fact is of importance, and holds good in the majority of cases of this nature. Another point of importance with regard to this disease is suggested by the discussion of the history of a case—namely, the origin of the blood which goes to form the hæmatocele. From whence does this blood proceed? The most common source is the mucous membrane of the body of the uterus, the place from which bleeding, in most cases of hemorrhage in connection with the internal genital organs originates. Doubtless, other sources exist, but this is the commonest one. The blood, issuing from the uterus through the Fallopian tube, discharges itself into the cavity of the peritoneum; there it excites some degree of perimetritis, which also produces adhesions, which contribute to inclose it. The site of a tumour thus formed must be of necessity within the peritoneum. Post-mortem dissections of cases fully corroborate this statement. The diagnosis of uterine hæmatocele is chiefly dependent on a consideration of the previous and subsequent history of the case. Its advent is characterized by suddenness, and, as has been already shown, is closely connected in many examples with the menstrual history of the patient. When the blood is poured out in large quantity, symptoms of loss of blood are present. Pain is not a constant phenomenon, but exists more or less in many cases, and is a result of the perimetritis which follows the effusion of blood into the cavity of the peritoneum. It is a remarkable feature of this disease that the tumour which forms in the abdomen often disappears so rapidly, that a swelling which was originally of large size is reduced in a few weeks to comparatively small dimensions, and, in a short time, all that can be detected is the remains of the perimetritis. The diseases with which it is most liable to be confounded are perimetritis and perimetric abscess, and, unless the case is a well-marked one, the differential diagnosis is not a simple matter. A consideration of the history of the commencement of the disease, and of its subsequent disappearance, will, in most instances, suffice to distinguish them from one another.—*Med. Times and Gaz.*, April 15, 1871.

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Cast of the Female Bladder.—Dr. J. R. Wardell exhibited an extraordinary pathological specimen, consisting of what seemed to be the exuviation of the entire mucous membrane of the urinary bladder, in a woman aged 28, admitted into the Tunbridge Wells Infirmary. The mass was absolutely seen to pass out of the bladder by the house-surgeon, Dr. De Havilland Hall. The following are the clinical details of the case furnished by Dr. Wardell.

M. B., aged 28, married, the mother of three children, was admitted on April 14th, 1871. On the 9th she had gone to bed apparently well. In the middle of the night she awoke up and tried to pass urine, but was unable to do so. The next day, at noon, a catheter was introduced, and the urine was drawn off. Retention continued until her admission. The secretion was fetid, and contained a large quantity of mucus. On admission, she complained of great pain over the pubic region, accompanied by straining and a constant desire to micturate, but all at-

tempts to do so were ineffectual. After she had been in the infirmary about half an hour, Dr. Hall was hastily summoned to the ward, as she had declared that something within her had "broken." On introducing the finger into the vagina, the legs of a fœtus were felt protruding, and in the course of an hour a fœtus of from three to four months was expelled. The placenta came away three hours afterwards. The patient was soon able to pass urine. During the next three or four days she had incontinence. The urine was very offensive, and contained a large quantity of mucus. Twelve days subsequently to admission, she was seized with great pain over the pubic region, which was only partially relieved by grain-doses of opium. On the morning of the 20th the house-surgeon was again hastily called to the patient. She was in excessive pain, and the cause of her suffering was ambiguous. Digital examination felt a substance being expelled; and visual inspection showed a mass of something in the process of being passed through the meatus urinarius. It was a membranous substance; it felt resisting and organized. After the lapse of half an hour, this slowly protruding mass was fully expelled. On examination, it almost seemed as if the whole of the mucous coat of the organ had been thrown off. At the moment of its expulsion the urine gushed out with great force and in large quantity. The woman from that time obtained instant relief, and continued to improve daily. She was treated with sedatives, and requested to drink large quantities of barley-water and milk and water. At the date when this case was related (May 10th) the secretion was nearly normal, and the patient was not at all troubled with a desire to micturate.

Dr. Wardell observed that he had referred to several works on pathology, but could find nothing resembling the case now narrated. He said he was confidently certain the mass passed out of the meatus urinarius, because the placenta had been thrown off in due time, and the substance, on minute inspection, had nothing of placental characteristics: it was too large, was not of the placental configuration, and not vascular, there were no tufts, and no signs of funal insertion; because on its inner surface there were gritty deposits, evidently consisting of oxalate of lime and uric acid; because Dr. Hall felt something like a foreign body when he introduced the catheter; and, above all, because the house-surgeon could not be mistaken when he said he saw it coming through the meatus. Again, there had been the common symptoms of vesical inflammation; there had been localized pain, a loss of the normal contractile power of the organ, a fetid secretion, and an abundance of stringy tenacious mucus. Dr. Wardell regarded the product as a croupous plastic exudation, just as we sometimes discover casts thrown off from the trachea, the bronchi, etc. The most remarkable feature in the case was the evident and speedy restoration of the function of the bladder. Having got rid of that which came to act like a foreign body as it were, the organ recovered its natural functions.—*Brit. Med. Journ.*, June 10, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Allopathy.—We have always and must continue to repudiate this epithet when bestowed upon scientific medicine as wholly inapplicable. It is a word invented by the homœopathists, and given to scientific medicine with the artful design of degrading the latter in the estimation of the ignorant to the level of homœopathy—a system founded upon a single idea, as are the systems of all the pathists. But scientific medicine never has been, never assumed to be, and never can be restricted to such narrow limits.

The devotees to *pathies* have their mental vision so clouded and limited by their one idea systems, that they see all things through a mist which strangely distorts them. We need not say to the scientific physician that to discern objects accurately, they must be viewed through a perfectly transparent medium—one free from all errors of refraction, and with the mind perfectly unbiased by visionary hypotheses.

Opium in the Treatment of Dysmenorrhœa.—Dr. Wm. Goodell states (*Medical Times*, April 15, 1871) that most of the forms of dysmenorrhœa are relieved during the attack by morphia, given either by the mouth or hypodermically. This could be explained by the threefold action of opium, for it is the best of narcotics, the most efficient relaxant of a rigid cervix, and an excito-motor of uterine muscular fibre—properties which meet many of the indications in dysmenorrhœa. In the congestive variety, in which the womb throbs like a headache, found usually in fat and plethoric women, chloral with hip-baths answered far better during the attack; but in the intervals the iodide of potassium, saline cathartics, and scarifications of the cervix are of great advantage. On the other hand, the effects of full doses of morphia are peculiarly happy in those nervous and neuralgic varieties of dysmenorrhœa so often met with in pale, thin, tall, and hysterical girls. The menstrual fluid accumulates in the cavity from a spasmodic closure of the internal os uteri, and escapes in gushes at such times alone as the expulsive pains overcome the resistance of such constriction. Opium is here the remedy *par excellence*, for it not only lulls the pain, but also takes away the cause of this pain by softening down and relaxing the rigid cervix.

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Belladonna in Typhoid Fever.—Dr. Lewis S. Pilcher, Asst. Surgeon U. S. N. (*Mich. Univ. Med. Journ.*), having been attracted by the positive and warm terms in which the effects of belladonna, given in typhoid fever, are stated by Dr. B. Kelly, of Dublin, finds that under its influence, within from 24–48 hours after the first administration of the drug, delirium, coma, and subsultus quickly vanish, and are succeeded by calmness and clearness of the intellect, by natural sleep, and complete control of all the voluntary muscles. Diarrhœa is checked, and healthy, consistent evacuations are established.—*Med. Record*, June 15, 1871.

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Hydrate of Chloral in Intermittent Fever.—Dr. F. A. Duzan, of Zionsville, Indiana, claims (*Indiana Journal of Medicine*, May, 1871) to have employed the hydrate of chloral successfully in the treatment of intermittent fever where quinia, arsenic, and other antiperiodics had failed. He gave fifteen grains five hours before the expected cold stage, and repeated the dose every hour until five doses had been taken. In one case narrated he repeated the doses on the day of the expected return, and after that there was no recurrence of the disease.

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Rupture of the Liver without External Evidence of Violence.—Dr. T. F. Dudley records (*The Medical Archives*, March, 1871) the following case of this:—

W. B., of this city, aged 28, of good physical and muscular development, was attempting, on Feb. 9th, to "couple" two railroad cars, when the coupling bar (fastened at one end) not being so guided as to make proper connection with the approaching car, was driven round with considerable force and struck him across the upper part of the abdomen, causing intense and continued pain. Good medical and surgical attendance was procured, but nothing could be done further than to partially allay his excruciating pain with anodynes, and he died on the 11th.

Upon post-mortem examination there was found no evidence of any bruise, nor even a scratch or abrasion upon the surface, but an abdominal section revealed a large amount of blood poured out in the abdominal cavity, from a rupture of the right lobe of the liver about two inches in length. No other organ was found to be injured.

The point of interest in this case is the very serious internal and fatal injury sustained without any mark or trace of violence upon the surface.

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Cundurango.—This is the title of a new drug lately discovered in Ecuador, a sample of which, with testimonials of its wonderful efficacy in the cure of cancer, has lately been transmitted by the American minister to that country to the U. S. Secretary of State. We have carefully read the testimonials as published in the

National Medical Journal for May last, and it appears to us that they are vague and unsatisfactory.

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Harvard University Medical School.—We have received the 88th annual announcement (Session, 1871–72) of this school, and must congratulate the Faculty on the decided advance they propose to make in the course of instruction. The plan of study in this school is to be radically changed.

"Instruction will hereafter be given by lectures, recitations, clinical teaching, and practical exercises uniformly distributed throughout the academic year. This year begins on the Thursday following the last Wednesday in September, and ends on the last Wednesday in June; it will be divided into two equal terms with a recess of one week between them. There is also a recess of one week at Christmas. Either of these two terms will be more than equivalent to the former 'Winter Session,' as regards the amount and character of the instruction. The course of instruction has been greatly enlarged, so as to extend over three years, and has been so arranged as to carry the student progressively and systematically from one subject to another in a just and natural order.

"In the subjects of anatomy, physiology, chemistry and pathological anatomy, laboratory work will be substituted for, or added to, the usual didactic lectures. Every student will have his place and time in the anatomical, physiological, and chemical laboratories, and in the microscope room; and laboratory work will be as much required of him as attendance at lectures and recitations.

"Instead of the former hasty oral examination for the degree of Doctor of Medicine, held at the end of the three years' period of study, a series of examinations on all the main subjects of medical instruction has been arranged. These examinations will be distributed for regular students through the whole three years; but they may be passed by other students either all at once at the end of their course, or, successively, at several times. Every candidate for the degree must hereafter pass a satisfactory examination in every one of the principal departments of medical instruction at some time during his period of study. The Faculty are convinced that this requisition will present no serious obstacle whatever to those who do not neglect their opportunities.

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The American Journal of Obstetrics, &c.—This valuable journal has changed publishers, and is now issued by Wm. Baldwin & Co., New York.

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The Virginia Clinical Record.—This is the title of a new monthly journal, of which two numbers have recently been published by M. W. Hazlewood, Richmond, Virginia. It has our best wishes for its success, and we welcome it to our exchange list.

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Obituary Record.—The No. of the *Virginia Clinical Record* for April announces the death of Dr. David H. Tucker, formerly Professor of the Practice of Medicine in the Medical College of Virginia. Dr. Tucker for several years was a resident of this city, where he secured many warm friends, and occupied for a time the chair of Midwifery in the late Franklin Medical College.

FOREIGN INTELLIGENCE.

Some further Additions to Therapeutics: Organic Bromides, Metachloral; with a note on Sulphur Alcohol.—Dr. Richardson read before the Medical Society of London (March 13) a paper entitled as above. The author first described the methods of research in therapeutics, which consist in following up modification of certain organic compounds by modification of the elementary composition of the compound. He then introduced some new medicinal bromides, viz., bromide of quinia, bromide of morphia, and bromide of strychnia, together with combinations of the same. Bromides are best administered in the form of syrups, each drachm of the syrup containing—in the syrup of the bromide of quinia, one grain of the bromide of quinia; in the syrup of the bromide of morphia, one-eighth of a grain

of morphia; and in the syrup of the bromide of strychnia, one thirty-secondth of a grain of bromide of strychnia. Compounds of the syrups of the bromides of quinia and morphia, and of quinia, morphia, and strychnia, were also useful. In each drachm of these the same proportion of dose, viz., one grain of quinia, one-eighth of a grain of morphia, one thirty-secondth of a grain of strychnia, was maintained. Dr. Richardson had found the bromide of quinia of great service in syphilitic ulceration. He had obtained most valuable results from frequently repeated doses of syrup of bromide of quinia and morphia in cases of neuralgia; and in a case of diabetes the syrup of quinia, morphia, and strychnia had been signally successful. The bromide of quinia he believed the best preparation in cases of remittent or intermittent fever. Dr. Richardson next brought forward bromal hydrate; it was less soluble than chloral hydrate, and produced more convulsive action, and, on the whole, he did not think it could at all replace the last-named substance. He then passed on to anhydrous chloral, placing before the society a specimen of pure anhydrous chloral, and, by the addition of pure water, it produced chloral hydrate. Chloral itself is a fluid caustic; it abstracts water rapidly, and might, he thought, be usefully employed as a caustic in some cases where soft fungous growths required to be removed. Chloral hydrate absorbed would be found to exert an after sedative influence. A specimen of metachloral was then shown, an insoluble white substance made by exposing chloral hydrate to sulphuric acid. This substance is isomeric with chloral, and, when treated with alkali, is resolved into chloroform and chlorate of the alkali employed. Administered to inferior animals, it seemed to act as a gentle narcotic; being probably slowly decomposed in the body, it may yet prove of service in practical medicine; lastly, Dr. Richardson exhibited a specimen of mercaptan, sulphur alcohol (C_2H_6S), in which sulphur replaces the oxygen of ordinary alcohol. He detailed a number of interesting facts bearing on the action of this agent, dwelling especially on the mental depression it produces even when taken in very minute quantities. The alcohol is exhaled by the breath as it passes from the bodies of animals, and communicates to the breath peculiar odours like the odour met with in wasting diseases. From this fact the author drew a suggestion for a new line of research in diagnosis, viz., the detection of organic sulphur compounds derived from the blood in the air expired from the lungs by diseased persons. Sulphur compounds liberated in the alimentary canal seemed harmless—*i. e.*, were not absorbed—but it was now quite certain that when some of them are actually introduced into the circulation, even in minute quantities, and are diminishable by exhalation from the lungs, they produce muscular debility, feebleness of the heart, and mental depression. We may, therefore, infer that the formation of sulphur compounds within the circulation from disease might account for some examples of excessive temporary prostration, for the cause of which we have as yet no satisfactory explanation.—*Medical Times and Gazette*, April 8, 1871.

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Neuralgia treated by the Constant Current.—Dr. Buzzard and Dr. Anstie reported cases to the Clinical Society (*Lancet*, May 20, 1871) in which this mode of treatment proved very effective. In Dr. Buzzard's case, a woman, aged 65, had suffered for three months from paroxysms of agonizing pain in the neck and right arm, which attacked her several times every hour night and day, deprived her of rest, and rendered her arm useless. The neuralgia had followed seizures which sufficiently indicated its central origin, and this, coupled with the age of the patient and the degeneration of the tissues, rendered its cure in the highest degree improbable. Applications of a sedative character had been useless in relieving her suffering. A constant current derived from ten cells (increased afterwards to fifteen cells) of a Weiss' battery was applied from time to time, between the cervical vertebræ and the hand, with the effect of producing remarkable relief to her pain, insomuch that at one time she thought herself cured.

Under the influence of this treatment the patient was enabled to sew, and to cut her food with the right hand, which had previously been so helpless that she was forced to lift it with the other. With the view of testing the effects of the application, it had been intermitted on several occasions, and other remedies, as blisters, sedatives, and tonics, had been employed, but these failed in preventing the paroxysms of pain. Summing up the results of treatment, Dr. Buzzard said that out of sixteen applications of the constant current, ten had been followed by very great and well-marked relief, two by moderate relief, and four by very slight relief. Dr. Buzzard brought the case forward, not as one of cure of neuralgia, but as a good example of the effects of the constant current in relieving pain; and he drew attention to the process because he believed it was as yet very little employed for this purpose in this country, although, as was well known, its efficacy had been perfectly recognized and insisted upon abroad for many years past. Dr. Anstie referred at the same meeting to two cases—one of severe neuralgia in the right cervico-brachialis in a married woman, aged 48; the other of double cervico-occipital neuralgia in an unmarried needlewoman, aged 30. In the former case a cure was effected; in the latter not. The constant current was employed, with a strength of ten cells, afterwards increased to fifteen; the positive pole in the first case being applied alternately on the various foci of pain, the negative pole being applied by the right side of the three lower cervical vertebræ. The pain was at once diminished, and ceased altogether at the end of thirteen days; and a secondary anæsthesia of the skin, with secondary paralysis of the deltoid and trapezius, were removed at the end of twenty-four days' treatment. The cure was found persistent six weeks later. Dr. Anstie remarked that the effect of the constant current in neuralgia was very remarkable, but that there were as yet some unexplained anomalies in its action. In the large majority of cases it acted as a palliative most strikingly. In a not inconsiderable number of cases it appeared to cure the disease absolutely; in a few examples it failed to produce any good effects. As a general rule it was far less effective in the neuralgias of old persons with degenerated tissues than in younger subjects; but occasionally even a young person, like the second of his cases, fails to derive benefit from it.—*The Practitioner*, June, 1871.

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Treatment of Obstinate Vomiting by Iodine.—In cases in which obstinate vomiting occurs after the administration of aperients, Caspar and Bierbaumb have found that the administration of iodine as recommended by Rademacher has been followed by excellent results. Thirty drops of the tincture of iodine, with a scruple of tragacanth, are added to eight ounces of water, and of this mixture a tablespoonful is to be taken every hour. These observers have found that gastric pain as well as vomiting subsides under the use of this remedy.—*Dublin Quart. Journ. of Med. Sci.*, May, 1871.

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The Nature of the Intestinal Lesion of Enteric Fever.—Dr. T. J. Maclagan, in a paper on this subject, read before the Medico-Chirurgical Society of Edinburgh (*Edin. Med. Journ.*, April, 1871), summarizes his views as follows:—

1. The intestinal lesion of enteric fever is specific in character.

2. It may terminate in resolution or ulceration.

3. When it goes on to ulceration there are two sets of lesions, primary and secondary.

4. The former are an essential part of the disease.

5. The latter are accidental, and the result of the inoculation of healthy glands by discharges coming from the former.

6. The recognition of these two forms of lesion is necessary to the explanation of the diverse phenomena of the disease.

7. Their relative frequency varies in different cases.

8. The extent of the primary lesions bears a direct relation to the severity of the attack.

9. That of the secondary bears no such relation, they being more likely to pre-

dominate in cases in which the general symptoms are mild, and the primary lesions few.

10. One primary lesion is sufficient to produce, directly or indirectly, many secondary.

11. The discharges do not necessarily inoculate every gland over which they pass.

12. The longer they remain in contact with a gland, the more likely is it to suffer.

13. The higher up in the intestine the primary lesions are situated, the more numerous, *cæteris paribus*, will be the secondary.

14. Fatal abdominal symptoms are more often the result of secondary than of primary lesions.

15. Relapses are caused by a reabsorption of the poison into the system, probably by one or more absorbent glands which escaped during the primary attack.

16. Constipation is to be regarded as a source of ultimate danger.

17. No one suffering from enteric fever should go more than two days without a stool.

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Gastrotomy for Internal Intestinal Obstruction.—Mr. Thomas Annandale, in some remarks (*Edin. Med. Journ.*, Feb. 1871) on this operation, arrives at the following conclusions:—

1. That when the symptoms of sudden and complete intestinal obstruction are present, and the ordinary means of treatment have failed to give relief, the operation of gastrotomy is jutifiable and advisable.

2. That the operation should not, if possible, be delayed beyond forty-eight or thirty-six hours after the first symptoms have appeared.

3. That the abdomen should be opened in the middle line; and that, during the operation and after it, every precaution should be taken to lessen the risks of peritonitis.

4. That when the abdominal cavity is opened, the best guide to the seat of obstruction is the contracted or dilated condition of a portion of the intestine.

5. That, if the intestine be gangrenous, or the obstruction not removable, its canal should be opened as near the obstruction as possible, and an artificial anus established.

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Fatal Result from the Intra-Uterine Injection of a Solution of the Sesquichloride of Iron.—Dr. Kern reports (*Würtemberg Med. Corresp. Blätter, No.* 7, 1870) a case of uterine hemorrhage after four successive conceptions and abortions, in a thin, weak, anæmic, and somewhat rachitic woman of thirty-six years of age. Various styptics were employed, among others an injection of a drachm of the liquor ferri sesquichlorati in ten ounces of chamomile water. A third injection of this solution, further diluted with tepid water, was very painful, induced uterine colic, followed next day by veritable metroperitonitis, which terminated fatally, thirty hours after the injection, in spite of the most appropriate treatment, such as leeches, cataplasms, ice, cold enemas, opium internally and subcutaneously, etc.—*Med. Record*, May 15, 1871.

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Raw Meat.—The use of raw meat in the treatment of disease is objected to by Mr. M. R. Levi (*Giornale Veneto*), unless the said meat be other than that of the ox or the pig. He recommends the use of chicken, pigeon, or turkey meat for this purpose, as the others are apt to produce the tænia.—*Med. Record*, June 15, 1871.

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Ought Consumptives to Marry.—Dr. Robert Barnes maintains that the problem—Is it to the advantage of the community, or of the individuals primarily concerned, that those bearing the seeds of tubercular phthisis should marry?—is one which medical science may properly discuss.

My own observation tells strongly on the negative or prohibitory side.

1. I have now seen a good many very sad instances where young men and women in whom consumption was either latent, stationary, or slowly progressing, have sunk rapidly after being "engaged," or after being married. The chance of recovery, or even of not getting worse, of a tuberculous sufferer, depends upon observing the strictest hygienic rules; and of

these rules a main one is the preservation of mental and emotional calm.

2. I have seen the effect of pregnancy and labour upon many consumptive women. I have no hesitation in saying that there never was a greater fallacy than that which affirms that pregnancy is antagonistic to phthisis. In my experience, labour commonly precipitates the fatal issue of the disease. Some perish during pregnancy; a large number sink rapidly after labour. This last trial breaks down the remaining forces of the system.

3. Consumptive people seem at least as apt in procreation as others. The children whom they bring into the world undoubtedly inherit the tubercular diathesis. How many of these perish quickly of convulsions, or, a little later, of abdominal or pulmonary disease! How few grow up to robust adolescence! And how large a proportion of those who survive to maturity repeat the sad history of their parents, scattering mental and physical distress around them!—*Brit. Med. Journ.*, Feb. 25, 1871.

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Pathology of Phthisis.—Dr. E. Aufrecht (*Berlin Klin. Wochenschrift*) summarizes 100 cases of tuberculosis (in Laennec's sense of the word) with the *post-mortem* appearances. The lungs were affected in ninety-two of the cases, and alone affected in forty-eight. In none of these forty-eight cases was any trace of true tubercle found. For these cases, therefore, Aufrecht recommends the designation cheesy broncho-pneumonia, except in those instances where a whole lobe is affected at once. Besides these forty-eight, in two others there was ulceration of the larynx, and in fourteen ulceration of the bowel, but in none of the sixteen was tubercle found. In other twenty-four cases the broncho-pneumonia was associated with actual tubercles, viz., four times on the pleura, and four times on the peritoneal covering of the bowel, whilst in sixteen they were found in various organs; only seven times, however, in the lungs themselves. In the remaining four cases of the ninety-two, the lungs were affected with tubercle only; other organs, however, being simultaneously involved. The author concludes that "The disease of the apices or upper lobes of the lungs, whether for a longer or shorter time confined to these, and known under the name of phthisis, never begins with the formation of tubercles, but always in the form of broncho-pneumonic accumulations. In this form the affection can run its course from beginning to end, the cheesy broncho-pneumonia being only in the minority of cases complicated by tuberculosis."—*Med. Press and Circ.*, May 31, 1871.

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Typhoid Fever with Constipation.—Dr. Murchison exhibited to the Pathological Society of London (*Lancet*, May 20, 1871) a specimen of typhoid ulceration of the intestine from the body of a man who had died suddenly from fatal hemorrhage into the intestine on the twenty-seventh day of the disease, and in whom there had been constipation. He brought forward the case—not a very unusual one—to disprove the common notion that continued fever with constipation is typhus, and with diarrhœa, typhoid fever. The case presented numerous other interesting clinical features.

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Dislocation of the Hip.—Dr. Eben Watson reports (*Glasgow Med. Journ.*, May, 1871) that four cases of this were treated by him at the Glasgow Royal Infirmary. "In all cases," he says, "the head of the bone was on the dorsum ilii, and in all it was easily reduced by manipulation. I know of no operation which a surgeon performs with greater pleasure to himself or benefit to his patient than this new or revived method of reducing dislocations of the hip, for which we are indebted to our American brethren. In some of my cases the dislocation was of old standing, and yet neither ropes nor pulleys were required."

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New Fluid for the Preservation of Microscopic Preparations.—Max Schultze, in the last part of his *Archiv für Mikroscop. Anatomie*, observes that of all fluids now in use for the preservation of microscopical specimens, glycerine, either pure or mixed with other reagents, is most widely employed. This substance, though possessing the peculiarity of rendering many

tissues transparent, yet unites with fats, and so modifies the differences of refraction occasioned by the presence of fat. Since the introduction of perosmic acid a new disadvantage attaches to glycerine—namely, that if the least trace of the acid remains, the glycerine becomes black, especially around the preparation, and there are no means of removing perosmic acid completely; washing, even when continued for days, being inefficient. Under these circumstances, M. Schultze has been engaged in seeking for a fluid which might replace glycerine, and has, he thinks, discovered one in a nearly concentrated watery solution of *acetate of potash*. According to Dippel, through whose work Schultze first became acquainted with it, it was originally employed by Sanio for the investigation of vegetable structures in place of chloride of calcium; and Dippel found it serviceable also for preserving animal tissues. Schultze applied the fluid in the same way as glycerine, a drop being allowed to flow over the specimen after it has been prepared in water or serum, without raising the cover. After the lapse of twenty-four hours the preparation is luted down. As the fluid neither dries up nor crystallizes out, the specimens may be long preserved in it. M. Schultze states that the solution has now been in use for two years in his laboratory, and no disadvantages have been found to attach to it, whilst it possesses all the advantages of glycerine.—*Lancet*, March 25, 1871.

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Cholera in Madagascar and along the Southeast Coast of Africa.—It is stated that cholera prevails to a considerable extent along the east coast of Madagascar, in the islands Mayota and Johanna (members of the Comoro group), at the northern extremity of the Mozambique Channel, and along the east coast of Africa, to the south of Port Mozambique, between the eighteenth and nineteenth degrees of latitude, about the mouths of the Zambesi River. The gradual extension of cholera in a southerly direction from Zanzibar, along the coast-line, towards the Cape Colony, is a subject of extreme importance, and suggests great difficulties in the establishment of the theory, supported by Inspector-General Lawson, of the advance of this disease by "pandemic waves" from south to north, along the belts inclosed by the isoclinal lines of terrestrial magnetic influence.—*Med. Times and Gaz.*, June 10, 1871.

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Alkaloid detected by Picric Acid.—Mr. Hager has found that this acid precipitates various alkaloids from their solutions, such as brucine, strychnine, veratrine, quinine, cinchonine, and some alkaloids of opium. Morphine and atropine, however, are precipitated only from neutral and concentrated solutions; but the precipitate dissolves pretty easily in water. Glucosides, caseine, and pseudomorphine resist the action of the picric acid.—*Lancet*, June 10, 1871.

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Deaths from Chloroform.—The *British Medical Journal* for April 22 announces two cases of this, and the *Lancet* for May 20th, a third.

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Von Graefe's Successor.—Prof. Schweigger, a pupil of the late eminent ophthalmologist, has just been appointed to succeed Graefe at the Charité Hospital of Berlin. Dr. Schweigger had hitherto occupied a chair in Zurich.—*Lancet*, May 20, 1871.

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Oppolzer's Successor.—Dr. H. Bamberger, at present Professor at Würtzburg, has been chosen to fill the chair rendered vacant by the death of Professor Oppolzer.

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Smallpox.—The number of deaths in London for the weeks ending May 6, 13, 20, and 27, were respectively as follows: 288, 232, 267, 257. The smallpox epidemic in London shows but little signs of decrease.

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Obituary Record.—M. Longet, the eminent physiologist, has just died at Bordeaux, aged sixty-eight. M. Longet was member of the French Institute, and of the French Academy of Medicine. His death, which was sudden, is ascribed by his friends to shock produced by the deplorable news from Paris.

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We are glad to welcome this treatise, and commend it, not only to medical men in general and those of our specialty, but to the members of the legal profession, as a book which cannot fail to be alike useful to all.—*American Journal of Insanity*, April, 1871.

A cordial welcome is due to Dr. Blandford's book, as being a most grateful addition to the literature of psychological medicine. We can assure every one that most valuable hints may be obtained from it when called upon to treat insanity or to take reluctant steps for placing insane patients under legal restraint. The Appendix, by Dr. Ray, supplies a positive want, and is a happy thought.—*Philadelphia Medical Times*, May 15, 1871.

Dr. Blandford's work is the latest and most practical on the subject.—*N. Y. Med. Gazette*, June 5, 1871.

The student or miscellaneous reader, who would pick up with little labor a clear and general idea of the subject of insanity in nearly all its bearings, will find this book better adapted to his purpose than any other that we know of. It is as lively as a novel in its style, and at the same time eminently practical. We hail it as a valuable acquisition to a department of medical science, the interest and magnitude of which increase every day.—*Pacific Med. and Surgical Journal*, June, 1871.

This book supplies a want much felt in this department of medical literature. No disease of equal frequency and gravity has been so imperfectly studied as insanity, and most works on this subject are too voluminous for the busy practitioner, who needs a concise manual for occasional reference, rather than an elaborate essay on the subject, and the work well meets the prevailing deficiency.—*Canada Lancet*, June, 1871.

Many points which our space will not permit us to notice, well deserve our attention. We must be content to recommend the work to the practitioner, with full assurance that in the careful study of it he will be repaid, as regards time and money.—*Indiana Journal of Medicine*, May, 1871.

We end as we began, in heartily recommending it as a most useful and reliable guide for the general practitioner. The synopsis of the laws in the different States of the Union, added in the American edition, will supply a want much felt by the practising physician.—*Am. Journ. Med. Sciences*, April, 1871.

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The author has been at great pains to collate the materials for this book. The sifting process has been judiciously performed, and the power of condensation has been carried to the utmost. For practical purposes, such books are no doubt very useful, although not altogether free from objection.—*London Lancet*, June 19, 1869.

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This is one of the handiest books with which we are acquainted. To the student of medicine in attendance upon lectures it will be found invaluable, and to the practitioner it will be found most convenient.—*Cincinnati Med. Repertory*, March, 1869.

This is a small sized octavo of 452 pages, containing an admirably condensed summary of the principles and practice of medicine. We do not hesitate to say that this work of Dr. Hartshorne is the very best of its kind.—*Chicago Med. Examiner*, March, 1869.

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GUERSANT ON SURGICAL DISEASES OF INFANTS, ETC. 16 PAGES.

CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Leucorrhœa. By LOMBE ATTHILL, M.D., Fellow and Examiner in Midwifery King and Queen's College of Physicians; Obstetric Physician to the Adelaide Hospital, Dublin.

GENTLEMEN: To-day I propose to call your attention to the subject of leucorrhœa, a word which literally means a white discharge, and for which the popular synonym is "the whites;" it is a symptom met with in connection with affections widely differing the one from the other, while the discharge itself varies greatly in colour, in consistence, and even in chemical properties. It is essential that you should bear in mind that though, as I have stated, leucorrhœa means a white discharge, the term is to be understood in a relative sense as opposed to a red sanguineous one, and that it includes all non-hemorrhagic vaginal discharges; thus very frequently it is of a light cream colour, sometimes of a yellow, or again of a greenish tinge; it may be inodorous or fetid, but nevertheless the patient is sure to tell you that she has The Whites. In its natural healthy condition the vagina while moist should not secrete any appreciable discharge, but hardly any departure from a perfectly healthy state of either vagina or uterus ever takes place, without leucorrhœa in some of its forms being present. You cannot have failed to remark, gentlemen, the extreme frequency of this symptom among the patients who have presented themselves here, and yet you have seen that the affections from which they suffered were very various. But before reminding you

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of the different abnormal conditions on which, as I have from time to time pointed out, these discharges depend, I must briefly enumerate the main characteristics which they present and the sources from which they proceed. As already mentioned, the term leucorrhœa includes a great variety of non-hemorrhagic discharges. It very commonly presents itself as a profuse mucous discharge, inodorous, and light in colour; or again as a thick creamy fluid coating the whole surface of the vagina and flowing into the speculum as you introduce it; then you have seen it so evidently purulent that, as I pointed out, it was impossible to say whether it was the result of gonorrhœal infection or not; in others it assumed a curdled appearance, or lastly was seen as a thick tenacious glairy secretion, issuing from and filling up the os uteri. Now it is quite evident that these various forms of leucorrhœa must not only depend on different causes, but also must be secreted by different parts of the genital canal. Accordingly we find vaginal leucorrhœa, cervical leucorrhœa, and uterine leucorrhœa, to exist as three distinct affections. The discharge, when proceeding from the vagina, is generally a light-coloured creamy-looking fluid unless acute vaginitis be present, when it becomes almost purulent; it often is secreted from the whole surface of the vagina, but in some cases, especially in children, it seems to proceed mainly from the vulvo-vaginal glands. Again, in some forms of ulceration of the os uteri the discharge is profuse and semi-purulent. That poured out by the cervical glands is very different in character; the glands situated in this part of the uterus are very numerous, and when inflamed secrete a copious tenacious albuminous fluid, closely resembling in appearance the white of egg; this discharge is so remarkable and so pathognomonic of disease of the cervical canal as to be unmistakable. Lastly, you may have leucorrhœa proceeding from the interior of the cavity of the uterus itself. The occurrence of this form of leucorrhœa is less easily recognizable than that of the others, but of its existence as a special affection I entertain no doubt; it is seldom that any discharge other than the glairy mucus secreted by the cervical glands is seen to issue from the interior of the uterus, but there is ample evidence to show that a copious discharge is under certain circumstances poured out from the mucous membrane lining the body of the uterus. This membrane performs a very important function—namely, that of secreting the menstrual discharge; it becomes at each catamenial period congested and thickened, and this great and frequently recurring change in its condition predisposes to the occurrence of disease, in addition to which there is also to be taken into consideration the vast alterations which occur in it during pregnancy and subsequent to delivery or abortion. As a matter of fact we find that the approach of menstruation is in most women ushered in by the appearance of a white mucous discharge, which there can be but little doubt is mainly secreted by this membrane, therefore that a similar discharge should present itself when it is the seat of disease is to be expected. In physical characters the discharge issuing from this source is often not to be distinguished from that secreted in the vagina, but while the latter has an acid the uterine discharge has an alkaline reaction, and it is the mingling together of these two fluids of opposite reactions which gives origin to the curdled appearance sometimes seen in the vagina.

The causes of leucorrhœa may be either constitutional or local. Anything which debilitates the constitution is liable to be accompanied by the appearance of a white discharge; thus it is seldom absent when lactation has been unduly prolonged, or again if a woman be debilitated by profuse menorrhagia she is nearly certain to be further weakened by the occurrence of leucorrhœa in the intervals between the menstrual periods. Again, it is met with in delicate girls, especially those of a leucophlegmatic temperament, in whom there exists a tendency to phthisis, and not infrequently in them it is the precursor if not the cause of the lung disease. Dr. Bennett, who for several years was engaged in practice at Mentone, a favourite resort as you are aware for consumptives,

remarked that great improvement frequently took place in the condition of many patients threatened with phthisis, in whom leucorrhœa existed, on that discharge being checked by appropriate treatment, a remark capable of easy explanation if we bear in mind how exhausting must be the effect of a profuse discharge so rich in albumen as is leucorrhœa. In cases which come under either of the heads I have alluded to—namely, debility arising from over-lactation or from the effects of a weakly strumous constitution, our treatment must be twofold—namely, first endeavour to check the debilitating discharge and then to invigorate the constitution and improve the general health. With the view of effecting the former you will order the use of astringent vaginal injections, those of alum or sulphate of zinc being the best, from two to four drachms of either salt being dissolved in a pint of tepid water. This quantity should be injected twice a day into the vagina by means of an ordinary siphon syringe, and at the same time you should by change of air when possible, by the adoption of a generous diet, and by the judicious administration of tonics, of which the preparations of iron are especially appropriate, endeavour to improve the patient's general health; but other cases of leucorrhœa are met with less amenable to treatment than these—namely, those which depend on the existence of visceral disease, such as that of the liver. Cases in which special treatment can do no good and therefore is to be avoided.

It would be tedious and unprofitable for me to enumerate all the constitutional causes which predispose to the occurrence of leucorrhœa. I may briefly sum up this part of the subject by saying that any disease which debilitates and enfeebles the health is likely to be sooner or later accompanied by leucorrhœa; but in addition to the numerous cases depending on disease of other organs or of the system at large, we meet with leucorrhœa as a symptom of local disease, and of none more frequently than that of inflammation of the vagina itself, or vaginitis as it is termed. You have seen over and over again examples of this. The mucous membrane lining the vagina, in common with that of all other parts of the body, is liable to inflammation of both an acute and chronic character; the latter however is much the most common. We have recently had under treatment two well-marked instances of acute vaginitis, one in a young woman, J. McComack. She stated that she had been married for four years, but had never been pregnant. She complained of burning pain in the vagina, of pain in the back, and of scalding on making water. On examining her, the entire length of the vagina was seen to be of a bright scarlet colour and very tender to the touch; the introduction of a small speculum, and even of the finger, giving great pain. The mucous membrane covering the os uteri was bright pink, the cervix itself being evidently congested. As the speculum was being introduced we saw a copious purulent discharge of a greenish-yellow colour to pour out from its sides. Now these cases of acute vaginitis are rare, and I always look on them with suspicion, accordingly I questioned this patient closely as to the possibility of her having contracted gonorrhœa; she said it was impossible; but be the cause what it may, we had here to deal with a case of acute inflammation of the mucous membrane of the vagina, and I treated it as I would similar inflammation occurring in any other part of the body If an oculist meets with a case of acute purulent ophthalmia, he endeavours in the first instance to arrest the progress of the inflammation by local bloodletting; I advocate the same practice in acute vaginitis. You may remember that in this case I punctured the cervix freely and encouraged the bleeding and ordered her saline purgatives, but I did not in the first instance make any application to the vagina. Caustics or astringents used at this stage would only have done harm. In the case I am referring to I punctured the cervix at intervals of a few days, and on each occasion abstracted a good deal of blood, and when the acuteness of the inflammation had subsided applied to the vagina a solution of nitrate of silver five grains to the ounce, and subsequently a stronger one

At the end of two months this young woman returned, having in the interval become pregnant. Now, had this woman been in hospital instead of attending as an out-patient, I should, in addition to the local abstraction of blood by puncturing or by leeches and the exhibition of purgatives, have prescribed warm hip-baths and directed the vagina to be syringed with infusion of tobacco leaves at least twice daily, which would not only have expedited the cure but also have alleviated the woman's sufferings. And these are the means I recommend you to adopt in your future practice; but, as I have already said, cases of acute vaginitis are of infrequent occurrence. This case afforded a good example of the difficulty of deciding between simple acute inflammation of the vagina and that depending on gonorrhœal infection. I must avow that I know of no means of distinguishing between them, but though acute vaginitis is not very often seen, subacute inflammation of the vagina accompanied by leucorrhœa is common enough and is the cause of much suffering; the burning pain in the vagina, the frequent desire to micturate, and the scalding on micturating, though not so severe as in cases such as the one I have just detailed, are constant and most distressing. The causes of these attacks are various; you meet them sometimes in young healthy women who generally attribute them to cold, but they are seen more frequently in married women in whom, in addition to the causes named, I am inclined sometimes to attribute their occurrence to the effects of too frequent sexual intercourse and of intercourse occurring too soon after a menstrual period or before the vagina has regained its normal condition after delivery. There is one form of subacute vaginitis which gives rise to very distressing symptoms; in it we see aphthous-looking patches on various parts of the vagina. I have invariably remarked that this condition of the vagina is accompanied by most distressing pruritus, not that pruritus does not occur in cases of vaginitis in which these aphthæ do not exist, for on the contrary pruritus is a very common accompaniment of subacute vaginitis, but it is most marked and nearly if not always present in conjunction with them; and here let me impress on you the uselessness of attempting to treat itching about the vulva without first ascertaining what the condition of the vagina and uterus may be, for you will seldom fail to discover either that inflammation of the mucous membrane exists or that the uterus is congested or ulcerated, and till these be cured all your efforts to relieve permanently the pruritus will fail. If vaginitis alone exist you will with the view of attaining this object, and at the same time of checking the pruritus which it causes, use in the first instance soothing applications and then astringent ones; of the former, none can compare with infusion of tobacco. It should be made by infusing two drachms of the unmanufactured leaf in a pint of boiling water. I have never seen the least unpleasant results follow its use, while the relief it affords has often been marked. Another mode of treatment of the greatest value is the application of glycerine; a roll of cotton-wool with a strong thread attached to facilitate removal and saturated with glycerine should be passed into the vagina through a speculum and allowed to remain there for twenty-four hours; this produces a copious watery discharge, which is often followed by very satisfactory results. Syringing the vagina with a solution of borax dissolved in tepid water, or an infusion of tobacco, is in such cases of great use; it should be used of the strength of about three drachms to the pint, and injected by means of one of the continuous siphon syringes manufactured by Maw and Co., on the principle originally suggested by Dr. Evory Kennedy. These syringes can be obtained at a moderate price of all chemists. The itching in these cases is sometimes almost intolerable. To relieve this most distressing symptom, I am in the habit of recommending the patient, after she has sponged herself with warm water, to lay inside the labia a piece of lint soaked in a lotion composed of carbolic acid ten grains, acetate of morphia eight grains, dilute hydrocyanic acid two drachms, glycerine four drachms, and water to four ounces.

Sometimes, when the vagina is excessively tender, medicated pessaries containing acetate of lead or tannin do good, but I do not think they can be relied on. You will generally find that this form of vaginitis is associated with a weakly state of the constitution, and that you are called on to administer tonics, and of these the mineral acids seem especially useful; but it does not follow because you cure the vaginitis that the leucorrhœa will disappear. Sometimes it continues when all symptoms of inflammation have subsided, and then you can use freely and with great advantage as injections, solutions of alum three drachms, or of sulphate of zinc two drachms to the pint; but often all our efforts fail to check entirely the discharge, and it becomes chronic or disappears only after a long interval. Before leaving the subject of vaginitis, let me caution you against pronouncing every little blush of redness which may be seen on the vagina to be inflammatory, or of attributing all the symptoms the patient may complain of to that affection. The leucorrhœal discharges of which I have hitherto been speaking are secreted from the various glands which surround the orifice of the vagina, and from the vaginal mucous membrane itself. A profuse semi-purulent discharge, which must be included under the term leucorrhœa, is secreted from the lips of the os uteri in a peculiar form of ulceration of that part of the womb to which I will in a subsequent lecture draw your attention, and of which you saw an excellent example in the case of Mrs. H——, recently discharged from hospital.

In nearly every case of leucorrhœa the discharge is much more profuse immediately after the menstrual period has terminated, and occasionally it seems to take the place of the latter which is then suppressed; in these cases the leucorrhœa is profuse at the date when menstruation ought to occur, and lessens considerably or nearly disappears for a time corresponding to the interval between the ordinary periods. This is likely to occur when the patient is debilitated by prolonged lactation, or by the existence of some constitutional disease. A white discharge, accompanied occasionally by a good deal of vascularity and irritation of the orifice of the vagina, is also not unfrequently met with in unhealthy strumous children; this has sometimes given rise to the suspicion that the child had been injured by an attempt at sexual intercourse, and you must exercise great caution in such cases, in giving an opinion; but unless strong confirmatory evidence exists, showing that an attempt at penetration has been made, I would have you slow in encouraging the idea. You may have recently seen an example of such a case in the children's ward; the little patient was but six years old. Cleanliness and a nutritious diet, with the exhibition of iron, speedily improved her condition; I also passed a camel's-hair pencil saturated in a solution of nitrate of silver up the vagina every four days, and she was soon quite well. You must also bear in mind that irritation about the vulva may be kept up in children by the presence of worms in the rectum.

Hitherto I have spoken only with reference to discharges of purely vaginal origin; we have besides, however, not only cervical but uterine leucorrhœa. You are all aware of the appearance which cervical leucorrhœa presents, I have called your attention to it so frequently. In its healthy condition the cervix uteri secretes a transparent viscid fluid in such small quantities as not in general to attract any attention or be observed when the speculum is introduced; but when the cervical canal becomes the seat of inflammation this secretion becomes not only much more profuse but thick and tenacious, blocking up the os uteri, and hanging out of it as a thick rope of viscid mucus which it is almost impossible to wipe away. Cervical leucorrhœa, or, as it is sometimes called, "cervical catarrh," is an effectual bar to pregnancy, in this contrasting with the other forms of leucorrhœa which do not necessarily cause sterility. The condition of the cervix giving origin to cervical leucorrhœa is one very difficult to cure; to do so you must treat the whole extent of the cervical canal, and this can seldom be accomplished without dilating it to an extent sufficient to enable you to

apply to its whole length a strong caustic such as the fuming nitric acid, to which I give the preference above all others; the application of solution of nitrate of silver and even of the solid nitrate itself will seldom be sufficient. If the case be not of very old standing the introduction of solid zinc points, as suggested by Dr. Braxton Hicks, often does good. You have seen me apply them several times with success; they cause a good deal of local irritation and give some pain, but this soon passes off.

I have already stated that leucorrhœa may proceed from the interior of the body of the uterus, the diagnosis of this form is less easily made than that of the others. It is generally accompanied by a greater or less amount of pain, which is not necessarily present in either of the other forms; the reason of this is easily understood, for uterine leucorrhœa is, I believe, nearly always the result of congestion of the lining membrane of the womb. When leucorrhœa is vicarious with, or, as already stated, takes the place of the regular menstrual discharge, it is probably from the interior of the uterus that it proceeds. Perhaps the present is the most suitable time I shall find for alluding to a practice, unfortunately of not very rare occurrence, which, while it destroys the health of the body if persisted in, impairs in no less a degree the powers of mind, and which is nearly always accompanied by leucorrhœa; I allude to masturbation. I do not believe all I have heard as to its great frequency, but that it is practised by many females is too true. In some I have no doubt it has been the result of uterine disease, the habit having been contracted accidentally, in the first instance, in the efforts to procure alleviation from the irritation which so often exists about the orifice of the vagina; but be the cause what it may, it is soon accompanied by vaginitis and endo-cervicitis, manifested by the presence of the well-known glairy cervical discharge. But beware of charging a patient with being addicted to this degrading habit because suspicious symptoms present themselves; the dilated pupil, the downcast look, the uncontrollable excitement which a vaginal examination causes generally, tell the tale—added to this, there is often a severe lancinating pain complained of, immediately over the pubes, and in several cases I have noticed that vomiting *at night* has been a prominent symptom. These distressing cases can be cured by moral means alone; local treatment is useless and generally injurious, for it attracts the patient's attention to the genital organs, the very thing we should be most anxious to avoid. I cannot find words sufficiently strong to condemn as I would the barbarous practice of mutilating the patient by the removal of the clitoris. This operation is as useless as it is disgusting, for there is no truth in the idea that in the clitoris alone is seated the nervous expansion which subserves the sexual orgasm.—*Dublin Medical Press*, June 21, 1871.

HOSPITAL NOTES AND GLEANINGS.

Brief Memoranda on Treatment. Charité Hospital, Berlin. (Communicated by Dr. Spencer Ferris.)

Ileo-typhus.—Traube distinguishes two stages in this disease. The first, which lasts about fourteen days, is characterized by swelling and ulceration of Peyer's patches. The second, which immediately follows, is marked by the process of sloughing; it is indicated by a morning temperature of normal, or less than normal, height, and a very high evening temperature. In the first stage the treatment consists of aqua gummosa and milk and soup diet. In the second stage excitants and stimulants are given; Rhine wine is the stimulant always used—never brandy. When the temperature rises to 40° C. (104° F.), Celsius's ice-bag is placed to the head. The mortality from this disease is not more than 3 or 4 per cent. Dr. Vreuzler states that out of the last 123 cases not more than 4 deaths have occurred. This appears to indicate that at Berlin the disease is of a mild character. In the same affection Frerichs gives no alcohol, and not always wine, but as much beef-tea, eggs, and milk as the patient can take, with nitric and muriatic acids. In hemorrhage from the bowels

he gives a quarter of a grain of acetate of lead, or a dose of tannin or sesquichloride of iron, with the addition of an ice-bag. Frerichs has also treated a few cases both of typhus and typhoid by baths and wrapping the body in cold cloths.

Acute Rheumatism.—Traube says that in persons under twenty-five, endocarditis, pericarditis, or some form of heart disease, almost always takes place; between twenty-five and thirty cardiac complication is not unfrequent, but that in those over thirty it is very rare. It may become developed, he says, whether the patient be in hospital or not. This is contrary to the experience of Dr. Gull, who says, in one of the "Guy's Hospital Reports," that if it is not established before the patient's admission, it does not come after. Traube envelops the limbs in flannel, never in cotton-wool; in light cases his treatment is entirely expectant. When limbs are much swollen, large blisters are used; in severe cases, where there is not much swelling, antiphlogistic remedies are employed. Frerichs gives half a drachm of iodide of potassium in the day, and when there is bad pericarditis or pleurisy he lays the ice-bag over the chest, as he says it eases the pain. He also gives infusion of digitalis. The ice-bag is especially resorted to when, with endocarditis, there is great excitation of the heart's action.

Pleuro-pneumonia.—Traube gives citric acid and aqua gummosa, warm applications, and in very bad cases takes blood from the arm. He finds that wine is very badly borne, and never gives it. His mortality is very small.

Peritonitis.—Traube rubs in a scruple of mercury ointment daily, till the mouth is affected, gives no opium, and allows the bowels to act when they will. He occasionally employs warm applications and leeches. He pursues the same treatment for puerperal peritonitis, in which his mortality is not more than twenty-five per cent. He distinguishes two kinds of puerperal fever, the "peritonisch" and the "phlebitisch"; the former he treats by inunction, as above, and the latter by quinia and tonics.

A Case of Ileus.—The bowels had not been open for nine days, and the patient experienced great pain in the bowels, and could not lie still. Traube gave him ice to suck constantly, and he had as much ice-water as possible injected up the bowel. But these measures had no effect, and in three days an artificial anus was made in the right inguinal region Three days after the patient was going on well.

A Case of Trichiniasis.—The first symptom was œdema of the eyelids and face, then pains in all the muscles and joints, followed by stiffness of all the joints, and then came contraction of the joints and a flabby swelling of the muscles, with high fever and high temperature. The treatment consisted in friction of the limbs with bay salt. Patients generally remain in the hospital six or eight weeks for this disease. As the malady recedes, the muscles often shrink and waste. Traube finds it of little use to cut out a piece of the muscle and put it under the microscope by way of aiding the diagnosis; for it is seldom that trichinæ are found in such a piece, although the body after death may be found to be full of trichinæ. Other reasons against the proceeding are, that the wounds made in people with this disease heal very badly, and if the patient does not regain full use of the limb the unfavourable result will be ascribed to the puncture.—*Lancet*, July 8, 1871.

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Two Cases illustrating the Diagnosis between Apparent and Real Intracranial Disease.—Under the care of Dr. John W. Ogle of St. George's Hospital.

Case 1.—W. W——, aged twenty-four, had been many years in India, and had had rheumatic fever three times. He had been in the habit of taking a great deal of stimulant. He had been much subject to headache and vertigo, and had had three "fits," preceded by headache. He had also been subject to severe pain at the epigastrium, and very frequently had had vomiting of food. For a month before admission he had vomited everything, he said, except brandy and soda-water. For some days after he came to the hospital he could only walk in a staggering manner, but otherwise there was no detectable alteration in muscular power, and

this appeared to arise from giddiness. This sensibility of the skin was everywhere entire. The special senses were intact, excepting that the sight was defective; and he stated that, *though he had never been obliged to wear spectacles, he had been couched in both eyes* many years before. The tongue was very red, and there was excessive constipation; but it was soon found that when the bowels were kept open by calomel and enemata, the headache and vomiting to a great degree ceased. The urine was free from albumen and sugar. The pulse and the temperature of the body were natural. Cold lotions applied to the head, with, on one occasion, a blister and aperients, assisted in removing the headache and the disordered locomotor power. The appetite improved under the use of calumba and mineral acids, and the patient in a few weeks recovered so far as to go out in a comfortable state, free from sickness, headache, or vertigo, which symptoms, though at first assignable to some positive cerebral lesion, appeared to have been merely the result of dyspepsia and constipation.

Case 2.—The patient, a labourer, aged fifty-eight, had been quite well until ten days before admission, when he lost his sight, he said, and was greatly troubled with vertigo. There had been no injury, no syphilis (according to his statement), no conclusive or paralytic symptoms, and no vomiting. On admission the sight was very defective, and there was great headache and *soreness of the scalp*. The pupils were contracted, the right one more so than the left; both acted sluggishly to light. The urine was found free from albumen and sugar, and the bowels were regular. No loss of power was noticeable in the muscles of the face, palate, or limbs. The voice and the swallowing power were natural. After admission he exhibited a great tendency to drowsiness, but in the course of three or four weeks this symptom, as well as others, have greatly diminished. The pupils are more dilated and natural. Examination by Mr. Carter with the ophthalmoscope showed atrophy of the optic nerve of both eyes, and depression of the surfaces of the optic disks, the result of atrophy. The patient is still in hospital.

The treatment has consisted of calomel-and-jalap purges, counter-irritation to the neck, and, latterly, of bromide and iodide of potassium, the latter being increased. Dr. Ogle suspects syphilitic intracranial deposit, or some other organic change within the skull.—*Lancet*, June 24, 1871.

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Purpura Hæmorrhagica, with Melæna, Hæmatemesis, Epistaxis, and Hæmaturia, following a Blow on the Cheek.—In the following case no family history of the hemorrhagic diathesis was obtained; but judging by the previous history of the patient—that he had bled freely from slight wounds on previous occasions—the case may be regarded in this light. The occurrence of the blow was probably little more than a coincidence.

Fred. A., six years of age, a very intelligent fair-haired child, with legs much bent from rickets, was admitted into St. George's Hospital under Dr. Fuller, on June 1st. It was stated that, while at play on May 29th, he struck his right cheek severely against a beam. The part became bruised and swollen; and, two days later, the eyelids of the right eye changed to a deep purple colour; the eye was noticed to be bloodshot; and numerous purple blotches appeared all over the body. The nose bled profusely. His mother had noticed on previous occasions that he bled very freely from slight wounds. There had been no deficiency of vegetables in his diet. On admission there were a bruise on the right malar prominence; a very extensive black eye and a patch of hemorrhage in the right conjunctiva; and numerous blotches of purpura, of various sizes, scattered over the face, trunk, and extremities. There was much epistaxis. Blood was vomited, was passed by the bowel, and was present in large quantity in the urine. He was at once ordered ten minims of tincture of digitalis in water every four hours; and good diet with greens, lemons, and watercress. The bleedings continued on the following day, and he became blanched and exhausted; but by the 3d instant

there was marked improvement, the urine being of normal colour, with a mere trace only of albumen. The digitalis was now reduced to five minims in quinia draught. By the 6th, the general bleedings had entirely stopped; the purpuric spots had nearly quite faded; and now (June 13th) he is convalescent, and mere traces of the former blotches remain.—*Brit. Med. Journal*, June 17, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

The Treatment of Varicocele.—Dr. J. H. Tyndall, House Surgeon, German Hospital, New York, in an article in the *Medical Record*, July 15, 1871, discusses the operations for varicocele, and makes the following deductions:—

First. The operations for the obliteration of the spermatic vessels afford but very temporary relief. In the few successful cases on record of subcutaneous ligature, the history of the case would doubtless show that only one vein was involved; hence the cure.

Second. Of the methods now in vogue, those attempting a support of the parts affected are alone admissible.

Third. The cause of varicocele being ascribable not to the veins of the scrotum, but to the pressure upon the spermatic plexus, the absence of a valve, and the emptying of several vessels into the epigastric vein at the internal abdominal ring, the indication is to apply the support in the neighbourhood of, or immediately at, the external abdominal ring.

Fourth. Any method of support (as by Evans' truss) at or near the external ring, aided perhaps by proper support of the scrotum and contents, is the only rational treatment for varicocele.

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Carbolic Acid for Venereal Vegetations (Cauliflower).—Dr. Eugene Brise finds (*Medical Record*, July 15, 1871) that pure liquid carbolic acid acts in these cases efficiently and with little or no pain. When applied, it seems quickly to penetrate through the entire substance of the vegetation, which shrinks in size and becomes white. After one or more applications the vegetations fall off, leaving no ulcer remaining.

Some of its principal advantages are: I. The acid may be applied in a liquid state by means of a camel's-hair brush; II. It does not appear to have any tendency to spread beyond the point of application; III. It causes no perceptible inflammation of the surrounding tissues if carefully applied; IV. It causes very little pain; and finally, V. It seems to be effectual; the vegetations disappearing, and, as far as my observation has extended, not reappearing.

The number of applications necessary varies, of course, with the size of the vegetations. I have never used it in those of large size, preferring to treat such by abscission, followed by the actual cautery.

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Lacto-Phosphate of Lime.—Prof. B. W. McCready states (*New York Medical Journal*, June, 1871) that he has found the lacto-phosphate of lime useful—1. In cases of defective nutrition, with or without diarrhœa, but without any acute disease of the alimentary canal, particularly when these conditions have occurred in prematurely weaned children.

2. In rachitis.

3. In atonic dyspepsia. In most of these cases, not only were the digestive power and nutrition of the patient greatly improved, but the appetite for food was augmented, sometimes to an extraordinary degree. Dr. William A. Hammond has found it of very great value in cases of nervous derangement, attended with impaired nutrition; and Dr. Barstow, of Sanford Hall, has used it largely in similar cases. It is very probable that the free lactic acid may, in many instances, contribute greatly to the efficiency of the preparation.

In a series of articles in the *Archives Générales de Médecine*, for Dec. 1867, and for Jan. and Feb. 1870, Dr. L. Dusart reviews the whole subject, and states that in four cases of tardy union of bone observed in the Hôpital Beaujon, the administration of the lacto-phosphate was attended with marked improvement of the fractured part; in three of the patients,

the appetite was at the same time greatly increased.

In a number of cases of rachitis, the influence of the lacto-phosphate was well marked, the children rapidly improving under its administration, the appetite at the same time being greatly increased.

Several cases of diarrhœa and indigestion, after resisting other treatment, quickly yielded to the influence of the lacto-phosphate.

Mr. Wm. Neergaard, of New York, prepared at the request of Dr. McCready a syrup of the lacto-phosphate of lime, and gives (*American Journal of Pharmacy*, June, 1871) the following formula for it: ℞. concentrated lactic acid, fℨj; magma of freshly precipitated phosphate of lime, q. s; Aquæ fl. aurant., fℨiss; aquæ puræ, q. s. ad fℨviij; sacchari albi, ℨxj. Mix the lactic acid with 2 fluidounces of water, and saturate it with the magma. Put the liquid upon a filter, and add the rest of the water until 8 fluidounces of filtrate are obtained. Pour this upon the sugar, contained in a bottle; shake occasionally until solution is effected, and strain. No heat ought to be applied, else the syrup assumes a milky appearance.

The syrup thus prepared contains between 2 and 3 grains of dry phosphate of lime in each fℨ, besides the lactic acid.

The dose for a young child is one to two drachms three or four times a day, while an adult may take a tablespoonful as frequently. The taste is pleasantly acid, and the syrup is not apt to disagree even with delicate stomachs.

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Disinfecting Solution.—Dr. Frank Wells, of Cleveland, Ohio, states (*Bost. Med. and Surg. Journ.*, May 25, 1871) that in the obstetric wards of the University of Vienna, all those who have examined any patient with a doubtful vaginal discharge wash their hands immediately afterwards in a solution composed of ℞ Potass. hypermang. ℨss; aquæ destillat. fℨij; M.; and to remove the stains of potash in a solution of ℞ Acidi muriatici. ℨvj; aquæ destillatæ, fℨxiv; M.

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Simple Method of Measuring the Specific Gravity of Small Quantities of Urine.—In the *Boston Medical and Surgical Journal*, Dec. 8, 1870, the following directions for this are given by an anonymous correspondent:—

Add to the quantity of urine to be examined as many equal volumes of water as may be necessary to float the scale of the urinometer. Multiply the excess of the specific gravity of the mixture above 1000 by the whole number of volumes employed, add to it 1000, and the result will be the specific gravity of the urine.

So simple a method as this can hardly fail to have occurred to many persons who have been engaged in examining urine, but I do not happen to have seen it mentioned in any of the books at hand, perhaps for this very reason. On the other hand, I have so often known the important fact of the specific gravity to be left out of a report on a specimen of urine for the want of enough to fill the urinometer, that the simple rule above given may not be without value to some of your readers.

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Statistics of the Medical Profession in the United States.—Dr. J. M. Toner, of Washington, D. C., has collected (*Boston Med. and Surg. Journ.*, July 6, 1871) the following interesting statistics:—

Whole number of physicians of all classes	49,798
" regular physicians	39,070
" homœopathic physicians	2,961
" hydropathic physicians	133
" eclectic physicians	2,860
Miscellaneous and unknown	4,774

This gives a ratio of 16.8 physicians to one homœopath in the whole number, and 13.1 regular physicians to one homœopath. Estimating the population of the United States in round numbers at 39,000,000, we have one regular physician to every one thousand of the population. The proportion of homœopathic physicians to the whole population would be about one in every 13,000.

FOREIGN INTELLIGENCE.

Ulcers of the Cervix Uteri.—M. Despres, Surgeon to the Paris Venereal Hospital for Women, in a recent work, states: "The diseases of women have often proved a rich mine to certain authors,

and the extensive practice derived from their writings has mostly been founded on the use of some new agent, hence the many remedies which have been proposed. On the other hand, we find unbiased men giving an account in their works of the therapeutical means which have been extolled, registering failures and occasional success. I am anxious to state my belief that the latter depends mostly on coincidences, and that the cures might have been obtained by other means. It should be remembered that most specialists in the diseases of women use but one mode of cure; such as the red-hot iron, lunar caustic, and more or less concentrated solutions of the latter; all, however, curing ulcers of the cervix in about the same lapse of time." M. Després ignores all internal remedies, and relies on topical applications. He considers, however, that complete continence, cleanliness, an occasional cauterization by any agent, are very efficacious, especially when patients are treated early, and subjected to constant control. The author adds that he has found the *plug* very useful, and gives the following description of it: Take a small piece of coarse gauze, in which a pledget of cotton-wool is placed after it has been filled with about 15 grains of powdered alum. Fold the gauze over the wool, and tie the ends of the former with a thread five or six inches long, which is allowed to hang out of the vagina to facilitate the removal of the plug. The latter should remain twenty-four hours.—*Lancet*, June 10, 1871.

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The Treatment of Itch in Children.—Upon the suggestion of Froehlich, A. Monti instituted (*Centralblatt f. d. Med. Wiss.*, April, 1871) some experiments upon the action of copaiba-balsam on the itch of children. He in the first place verified the fact that the freshly-captured itch-insect dies in from two to three hours when placed in copaiba-balsam. The balsam produces on the skin an active redness and burning, which disappear after half an hour, and with them also the troublesome itching. After three or four inunctions, spread over one or two days, the efflorescence of the skin grows pale. No disturbance of the digestion nor of the urinary organs was noticed in any of the cases. The duration of the treatment varies between two and twelve days. The scabies nodosa, without eczema, is the most readily healed—the balsam has no influence upon eczema or upon pustules. The balsam of copaiba is cheaper than that of Peru, is to be preferred on account of its more agreeable odour, and does not stain the linen.

Monti experimented with carbolic acid, employed either in solution (one to two drachms to one pound of water) or in the form of salve, ʒj to ʒiv unguent. simpl. After a preliminary washing, the carbolic acid is vigorously rubbed into the diseased parts of the skin. In scabies pustularis, poultices are used instead of the initiatory washing or baths. The redness and burning of the skin caused by the carbolic acid soon disappear. Any eczema present is speedily cured. The duration of the treatment is very short; as a rule, six to nine inunctions, in the space of two to four days, suffice; if eczema is present the treatment is somewhat protracted. This method is much to be recommended for children.—*New York Med. Journ.*, July, 1871.

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Chloral in Phthisis.—The *Gaz. Farm. Ital.* advocates the addition of chloral hydrate to cod-liver oil; it renders it much less nauseous, and prevents the night-sweats of the phthisical patient, induces sleep, and creates appetite. It is prepared as follows: Ten gr. pure chloral hydrate crystals with 190 gr. cod-liver oil, digested in a sand-bath with gentle heat. Dose, six tablespoonfuls daily.—*Med. Times and Gaz.*, June 24, 1871.

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Liniment for Fissure of the Anus.—M. Van Holsbeck states that he has succeeded in curing anal fissures with the following application, which had resisted the division of the sphincter. Dissolve one part of tannic acid in 16 parts of glycerine.

A tent wet with this preparation, is to be introduced into the rectum night and morning. The bowels are to be kept open. —*Revue de Thérapeutique*, April 1, 1871.

Plugging the Nostrils as a Precautionary Measure.—M. Verneuil, in a paper published in the *Bulletin Général de Thérapeutique* for May 30, recommends plugging of the posterior nares as a precautionary measure in all cases of operation on the face where there is danger of the passage of blood into the pharynx. Besides preventing this as long as the soft palate is uninjured, the plugging also, M. Verneuil says, enables chloroform to be given during the whole operation. It ought to be done before the induction of anæsthesia is commenced.—*Brit. Med. Journ.*, July 8, 1871.

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Local Anæsthesia.—Dr. Spessa states, in the *Bulletin*, that he has succeeded in preventing pain, during the slitting of a fistulous tract, by injecting a solution of morphia into the tract before the use of the knife. The same author had occasion to touch the vulvar vegetations of a girl with butter of antimony; the pain was very acute, but disappeared on the part being brushed over with a solution of morphia. A boy of fifteen, suffering from hip-joint disease, required an issue over and behind the great trochanter. An injection of morphia was first made over the region, and Vienna paste applied, which latter remained about eight minutes. The paste did not give any pain. Dr. Spessa states that he would be glad to hear that a fair trial has been given to this mode of using morphia.—*Lancet*, June 10, 1871.

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Cast of the Urinary Bladder.—In the number of the *Medical News* for July, 1871 (page 103), is reported a case of this which occurred in the practice of Dr. Wardell. In the *British Medical Journal*, June 24, 1871 (page 668), Dr. Wardell has collected the notes of several other cases, and Dr. J. J. Philips (page 662) refers to five cases and records a hitherto unpublished one which came under his own notice.

Mr. Spencer Wells has presented to the Museum of the College of Surgeons two specimens of this, which he describes as follows (*British Medical Journal*, July 1, 1871):—

In one of my specimens, the uterus and bladder are seen, as well as the detached cast of the bladder, covered with a gritty deposit of urates and phosphates. The walls of the bladder are thick and contracted, the muscular fibres being distinctly visible. The detached mass which was lying loose in the bladder I described at the time as "degenerate epithelium holding together saline deposit. On boiling a piece of it in twenty parts of water to one part of acetic acid, much of the saline matter is dissolved, and some of the tissue becomes clear, looking like smooth muscular tissue which has begun to degenerate by the deposit of fatty or albuminous particles in its substance." (*Obstetrical Transactions*, vol. iii. p. 354.)

The patient was twenty-two years of age. After a natural labour with her first child, the bladder was not emptied for sixty-two hours. Five pints of turbid bloody urine were then drawn off. Cystitis followed, incontinence of urine, and a train of distressing cerebral symptoms, ending in death two months after delivery.

The second specimen I exhibited at the Obstetrical Society on the evening of the day when it was voided by the patient, six weeks after a severe instrumental labour. The report may be seen in the the third volume of the *Obstetrical Transactions;* and in the fourth volume there is an elaborate report on the specimen by Dr. Harley.

From the time of her labour the patient suffered from severe cystitis with nephritis. Three weeks after labour, the urine contained albumen, blood-corpuscles, pus-cells, chylous matter, and renal tube-casts. The urine, when quite fresh, was loaded with carbonate of ammonia. A hard swelling had been felt through the anterior wall of the vagina; and on the day before the specimen was expelled through the urethra, Mr. Marshall, the surgeon in attendance, had observed shreds of sloughy membrane protruding through the urethra. After it came away, the health of the patient rapidly improved. I have lost sight of her; but Dr. Harley saw her in good health between two and three years after the illness.

My second specimen differs from the first in being a more complete exfoliation of the bladder. It is a bag of animal membrane—involuntary muscular fibres interlacing over its outer surface—the interior being a smooth mucous surface, covered with crystalline phosphates and urates.

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The Value of Extract of Meat.—Liebig's extract of meat has now been long enough before the world to enable most men to form their own opinions as to its specific value as an article of food and as an article of medicine. Nevertheless, it may not be amiss on our part to point out what has been ascertained as to its worth, and to indicate as exactly as possible the uses to which it ought to be put.

Meat as an article of diet owes its value partly to the mineral substances it contains, partly to the organic compounds, albuminoid and oleaginous. The mineral substances probably undergo little change in the human body, and with the oleaginous we do not now concern ourselves, but the albuminoid, having been ingested, are in the stomach reduced to a uniform substance, termed albuminose or peptone, by means of the acid and pepsine of the gastric secretion. All albuminoid bodies are so reduced—albumen, fibrin, etc.—and this new substance has the special property of diffusibility, a property altogether wanting in albumen itself. But straightway the process of degradation commences, and a multitude of new compounds—kreatin, kreatinin, leucin, tyrosin, etc.—are formed, but the force evolved in the change is the force manifested by the body—in other words, life implies these changes and the ultimate conversion of albumen into urea.

Let us now apply these physiological facts to the study of meat extract, and we shall find something worthy of our attention. Let it be noted, then, that over and above the *juice* of meat there is some available material in its *substance*, for this is soluble in the stomach.

In the extract, substances which exist only in very small quantities in normal meat are increased a hundred-fold, whilst the really important and nutritious substances are actually diminished. Animals have no constructive power; that resides in vegetables. Albumen having ceased to be albumen and become kreatin, can never be again converted into albumen in the animal economy; it can only proceed on its retrograde course to end as urea. This being so, it is evident that the nutritive value of meat extract, in respect of its albuminoid constituents, must be but small.

Some time ago, Kimmerich, in an article in *Pflüger's Archiv*, astonished, and we might say frightened, the world by announcing that Liebig's extract was actually poisonous. He has, however—so to speak—reconsidered his opinion, and, in a recent article in the *Deutsches Klinik* has been at pains to point out the actual value of this substance. First, then, it causes a sensation of warmth in the stomach; it strengthens the heart's action and the circulation generally—in short, it acts as a stimulant rather than an article of food. In its action it is allied to tea and coffee rather than to the meat whence it is derived. Those familiar with meat extract know that it consists in considerable part of salts, such as are actual constituents of the animal frame, and in this respect, wherever these salts are deficient, as in rickets, the use of meat extract may be supposed to be beneficial. So, also, in cases of sickness will the solution of extract properly flavored prove of value as a stimulant, in the same way that a glass of wine will enable a man *immediately* after he has taken it to do what he was incapable of doing before. But however useful in debility, it is now a well-recognized fact that wine is not food, and so with meat extract. We have already pointed out what we considered to be the proper place of extract of meat as an ordinary article of diet—viz., to give taste and relish to a mass of nutritive but insipid material; we now seek to enforce the same view as to its medicinal application. Patients will swallow large quantities of this extract, thinking they are imbibing nutriment proportional to the quantity of meat employed in manufacturing the extract. A patient may be swallowing several ounces of extract daily

and yet be actually starving; he may feel better for it, but his strength will not return, except he can swallow something else as well. It is needless to point out the importance of this fact to practical men. It carries its own application with it. No patient should be allowed to pass through an illness with this alone as nutriment, except it be subsidized by the addition of other more nutritive material. A bone added to it and boiled in it for a time is a great improvement; thickened with corn flour (not starch alone), it is most valuable; by itself, it is not to be trusted. If these facts be borne in mind, we shall have done good service in again directing attention to Liebig's extract of meat.—*Med. Times and Gaz.*, June 24, 1871.

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A Leech in the Pharynx.—M. Trolard says, in *L'Algerie Médicale*, No. 29, 1870, that a lady rather hastily drank a glass of unfiltered water, and the next day felt some tickling towards the larynx. Having examined the pitcher whence the water had been obtained, she found seven small leeches. Nausea and spitting of blood continued, and much pain was felt about the pharynx. With the laryngoscope M. Trolard saw a leech curled up in the groove which, on the right side, runs along the larynx. The leech was seized with appropriate forceps, and removed with some difficulty, as it clung tenaciously to the part.—*Lancet*, Feb. 4, 1871.

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Death from Chloroform.—Another death from chloroform occurred at the Great Northern Hospital, London, on May 31st. The patient was a boy aged eight, who had been under treatment for some months for a severe burn, occupying the dorsal and lumbar regions, with protracted stage of ulceration, for the cure of which skin-grafting had been several times attempted. The pain caused by dressing the wound was so great that it was thought expedient to administer chloroform on the occasion on which the fatal occurrence took place. The chloroform, which was given while the patient lay on his abdomen, had been discontinued for several minutes, when it was observed that breathing had ceased. Every means was adopted to resuscitate life, but without avail.—*Brit. Med. Journal*, June 10, 1871.

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Damage sustained by the Medical Institutions and Members of the Profession in Paris.—During the late dreadful scenes in Paris, the medical men in passing to and fro to the various ambulances, were constantly exposed to the most imminent risks. The danger, indeed, was not confined to the outside, as balls and shells often penetrated to the interior of the hospitals, as well as of the houses. Several have, however, been severe sufferers in their property, their houses or apartments having been burnt, together with their libraries, manuscripts, and various objects whose loss is irreparable. Among the sufferers are, MM. Dechambre, editor of the *Gazette Hebdomadaire*, Laboulbène, Genouville, Martineau, Audhoui, Paris, and Lacroix. Others, by their courage, presence of mind, and energy, succeeded in saving their own and neighbors' houses from the flames when menaced by incendiaries. Thus, M. Linas saved the one he inhabited in the Place de la Madeleine, by establishing an ambulance in the courtyard, and receiving the federal wounded. In the Rue de l'Université, M. Léon Lefort, revolver in hand, stemmed the advance of the incendiaries, and compelled them to retreat. Several of our *confrères* were among the most active in directing the extinction of fires already commenced. M. Amédée Latour, the well-known editor of the *Union Médicale*, has been placed in a deplorable position, having been closely shut up in his own country house at Chatillon, unable to leave it under peril of his life, and constantly exposed to the fire of the neighboring forts and batteries.

The Sorbonne and the Ecole de Médecine are entirely uninjured; and of all the great libraries of Paris, that of the Louvre is the only one that has suffered. This, however, which contained 100,000 volumes, many of them of great value and rarity, is utterly destroyed. The Mazarin library, which was at one time stated to have been burned, has been preserved intact. A magnificent edifice forming an

annexe to the Hotel de Ville, and employed in the administration of the Assistance Publique, has been entirely destroyed. None of the hospitals have suffered otherwise than by reason of their propinquity to the various scenes of combat; but the Lariboisière, St. Louis, Necker, and Pitié have sustained much damage in this way. The Hôtel-Dieu may be said to have had a narrow escape, for it was mainly due to the exertions of M. Hanot and other *internes*, made at the risk of their lives, that the attempts at burning the adjoining Notre Dame were defeated. At the Luxembourg Palace, again, the ambulance was the means of saving it from destruction. The agents of the Commune insisted that the ambulance should be evacuated, in order that the petroleum which they had brought might be ignited. M. Danet, who, with M. Brochin and other medical men, was in charge, sought by every means to obtain delays, telling the incendiaries that their own wounded would unavoidably fall victims. They succeeded in staving off the danger, which grew every moment more imminent, until, at last, the marines of the Versailles force arriving, the rebels retreated. The palace suffered to some extent from the explosion of a powder depôt, which took place soon after; and one of its *façades* has been terribly mutilated by shell and ball. The apartments of M. Lucien Boyer, containing valuable furniture, were demolished by shells.

In the *Gazette Hebdomadaire* for June 2, M. Linas gives a very graphic account of the terrible scenes which passed around his house in the Place Madeleine during the dreadful days and nights of May 22, 23, 24, 25, and 26.—*Med. Times and Gaz.*, June 17, 1871.

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Mortality of Paris during the Siege.—The following statement of the mortality of Paris from the 18th Sept. 1870, to the 23d Feb. 1871, compared with the mortality during the same period in the preceding year, furnishes some idea of the sufferings undergone by the Parisians during the nine weeks of siege and four weeks of armistice.

Deaths during the former period, 64,154.

Deaths during the corresponding period of the previous year, 24,978.—*Revue de Thérapeutique*, April 1, 1871.

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Smallpox in London.—The number of deaths in London, from smallpox, for the weeks ending June 3, 10, 17, and 24, was respectively as follows: 229, 245, 240, and 232.

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Dr. Frerichs.—It is stated in the *British Medical Journal*, July 8, 1871, that the order of the Iron Crown, of the second class has been conferred on Dr. Frerichs, of Berlin, whose classical work on the liver has made his name well and favorably known.

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Mr. Paget at St. Bartholomew's.—On July 4th, the Prince of Wales, in his official capacity as president, paid a visit to St. Bartholomew's Hospital, accompanied by the Princess of Wales, the Princess Louise, and the Marquis of Lorne. The occasion was to present to Mr. Paget an illuminated copy of the resolution in which the General Court of Governors expressed their sincere regret at his resignation of his office as senior surgeon to the hospital. The Prince, in handing the resolution to Mr. Paget, expressed, in cordial language, his own concurrence with its terms; and Mr. Paget returned thanks with that happy blending of dignity and modesty which is so peculiarly his distinguishing characteristic.

Mr. Paget has long since earned the undying gratitude of the poor; and we trust that he will long continue to earn the "gratitude with recompense" of the rich. —*Lancet*, July 8, 1871.

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St. Thomas's Hospital, London.—The magnificent structure erected on the Thomas Embankment for the accommodation of this venerable institution, was formally opened on the 21st of June, by Her Majesty the Queen. The staff includes Drs. Peacock, Bristowe, Clapton, Murchison, and Barnes; Messrs. Le Gros Clark, Simon, Sydney Jones, Croft, and Liebreich; Drs. Stone, Ord, John Harley, Payne, and Gervis; Messrs. MacCormac, Wagstaff, F. Mason, and H. Arnott.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on the Simple Tumours of the Breast. By CHRISTOPHER HEATH, F.R.C.S., Surgeon to the Hospital for Women, and Asst. Surgeon to University Hospital.

GENTLEMEN: In my last lecture (see No. of *News* for June, 1871, p. 81) mention was made, incidentally, of collections of milk occasionally occurring in the ducts or sinuses around the nipples, and commonly known as lacteal tumours, the treatment of which is sufficiently simple. There is, however, another and more serious form of cyst in the breast containing milky fluid or its remains, which is occasionally met with, and which is known as *galactocele*. These milk-containing cysts occur during lactation, and undoubtedly depend upon obstruction and dilatation of one or more of the milk-ducts in the substance of the gland. They are slow in progress, and may exist during many months before they come under the notice of the surgeon; and there seems little doubt, from the researches of M. Forget, that, when of large size, the over-distended tube gives way, and the wall is formed by the breast-substance. The tumours present all the ordinary signs of fluctuation, &c., when of large size and near the surface; but are very difficult of diagnosis when deeply seated. The size they may attain to is well shown by one of the earliest cases on record—namely, that of Scarpa—in which the tumour measured more than thirty inches round, and gave exit to ten pints of milk when punctured with a trocar. The contents of a galactocele may not, however, always be fluid milk; for a process of

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absorption of the watery portion of that fluid occasionally occurs, and a creamy or even cheese-like mass is consequently left, of which last an example is to be seen in Guy's Hospital museum.

The treatment of the simple collection of milk around the nipple is to lay it open, and the same treatment will be most effectual in the case of the other form of galactocele, if near the surface. If deeply situated, however, it will be well to try the effect of an oblique puncture with a trocar and canula, by which the contents will be evacuated; when possibly, as suckling ceases, the cyst will heal up. Extirpation of the cyst is the last remedy.

Quite irrespective of lactation, however, cysts may be developed in the breast; and though occasionally single, they are more often extremely numerous, and are scattered through the gland, as may be seen in the specimen before you. In considering the pathology of these cysts (the serocysts of Brodie, or the improperly called hydatids of Cooper), we find almost as much contradiction between observers as on the allied subject of cysts in the kidney. You will remember that two opposite theories are held with regard to renal cysts, Rokitansky and Simon maintaining the formation of these cysts from an enlargement of the cells or primary anatomical elements of the kidney, whilst George Johnson and Gairdner uphold their formation from obstructed ducts only. In the same way Birkett maintains the formation of cysts of the breast by obstruction and dilatation of the minute ducts, whilst Broca strongly upholds the formation of new cysts in the substance of the gland itself, and Virchow believes in both methods of formation. Mr. Birkett believes that, a duct happening to become obstructed, the walls become dilated or varicose, whilst the portions of the duct between the dilatations become contracted and eventually obliterated. The tortuosity of the ducts would thus account for the numerous and closely adjacent cysts so often seen, and the different angles at which the ducts would be cut in a section of the gland would account for the difference in the shape of the cysts. On the other hand, M. Broca (*Traité des Tumeurs*, ii. p. 84) maintains that all the cysts, whether large or small, are independent of the ducts, and that were they derived from the ducts the smallest cysts could not have the completely spherical form which is common to them, but would be more or less tubular or ellipsoidal. M. Broca allows, however, that the larger cysts may be due to obliteration of the ducts, and I think the point already mentioned with regard to the angle of section of a tube may explain the globular appearance of the small cysts. Most museums contain specimens of the disease, and the illustrations given in the plates of Sir Astley Cooper's work, which is before you, sufficiently elucidate the subject, although all forms of cyst were erroneously classed together by that eminent surgeon under the term "hydatids."

I am inclined to think that, whatever may be the origin of the numerous cysts which are found scattered through the breast, there can be no doubt that the large single or multiple cysts found in the neighbourhood of the nipple depend originally upon an obstructed duct; and hence the term "duct-cysts" given by Mr. Birkett in his recent essay in *Holmes's System*, is an excellent one. That these cysts are true duct-cysts, is proved by the fact that frequently by the exercise of gentle pressure some of the fluid may be forced out from the nipple, or may even flow from it spontaneously. This fluid is usually of a viscid, mucoid character, and varies in colour from straw-colour to a greenish-brown. The progress of the tumour is slow and painless, and, if near the nipple, the diagnosis of fluctuation is easy; but if the fluid is deep, and therefore difficult of recognition, recourse should be had to an exploring trocar or needle in order to clear up the doubt. It is to be borne in mind, that cysts occasionally coexist with cancerous tumours, and therefore the presence of fluid or its extrusion by the nipple is not a certain proof of the innocent character of the disease, if there is a distinct tumour left when the cyst has been emptied; or cancer may develop in a breast the subject of cystic disease for many years, as in a case recorded by Mr. Erichsen.

The treatment of these duct-cysts is unsatisfactory, unless complete removal of the cyst is performed. Last autumn I attended, with Dr. Whitmarsh, of Hounslow, a case of the kind in the breast of an unmarried patient who had been subjected to a variety of treatments, including injections and laying open the cyst, without benefit. I dissected out the cyst, and then found that its interior was lined with long papilliform growths of granulations, the result, no doubt, of irritation, but which effectually prevented any contraction or closure of the cyst. When the cysts are numerous, amputation of the breast will be required.

The *sero-cysts*, so well described by Sir Benjamin Brodie, may be found in any part of the breast, and are of very variable size. They are well represented in Plate 1 of Sir Astley Cooper's *Illustrations of Diseases of the Breast*, and are also seen in the preparations before you. The fluid contained in the smaller cysts is generally viscid and gelatinous, though clear; but in the larger cysts it is usually serous and limpid; and the evidence of fluctuation when near the surface is more distinct than in the case of the duct-cyst. Even in the smallest cyst a distinct epithelial lining will be found, and Broca relies upon this fact as conclusive of the fluid accumulating in a glandular cavity. When the cysts become much enlarged, the epithelial lining ceases to be continuous, but evidences of its existence are always present. The progress of the disease is slow and painless, as a rule, and it may subside altogether under treatment. This consists in the ordinary discutient applications, such as iodine, iodide of potassium ointment, &c., or the lotion of camphorated spirit and lead recommended by Brodie. If the skin over the cyst becomes thinned, evacuation of the cyst should be performed, when, if it does not close, it may be removed, or, in the case of numerous cysts, the breast must be removed.

The true *hydatid cyst* is of rare occurrence in the breast, Sir Astley Cooper giving only one real and one doubtful case, and Mr. Birkett having seen but two examples. The parasite is the ordinary acephalocyst, containing numerous echinococci floating in clear fluid, and is usually single. There are no means of distinguishing this from any other cyst, except by a microscopic examination of the fluid, when the characteristic hooklets of the echinococcus would be readily identified. Removal of the cyst (of which a drawing is given by Sir A. Cooper), and even removal of the breast itself, has been practised in these cases; but seeing how effective experience has shown the simple operation of tapping the cyst to have been in destroying the parasite and causing shrinking of the cyst in the case of the liver, it is not unreasonable to suppose that similar good results might follow a simple evacuation of the contents of the cyst in the breast; and I should certainly give the plan a trial in any case of the kind that came before me. In the museum of the Middlesex Hospital is a specimen of hydatid cyst which occurred in the practice of Mr. Mitchell Henry, and was found between the breast and the pectoral muscle, and adherent to both.

Sero-cystic sarcoma was the name given by Sir Benjamin Brodie to a form of disease which he first accurately described, although it is doubtless the disease referred to by Sir Astley Cooper as one of the forms of "hydatid" tumour of the breast. According to Brodie the disease begins by the formation of a cyst containing serous fluid, from the interior of which a solid growth takes place, filling up the cavity of the cyst more or less completely. By the gradual development and pressure of these intra-cystic growths, the skin covering the tumour may become thinned and ulcerated, and eventually a fungoid growth may protrude. This filling-up of the cavity is, however, by no means of constant occurrence; and not unfrequently large cysts are found in connection with sero-cystic sarcomata, as in the drawing I show you from Sir A. Cooper's *Illustrations of Diseases of the Breast*. This intra-cyst growth has been accepted by Mr. Paget as the correct explanation of tumours of the class described by Brodie; but he has put them under the heading of "proliferous mammary cysts," and has variously described the contents ac-

cording to their shape, size, and colour. These growths are generally allowed to be glandular in their origin; though in some cases, according to Paget, it is impossible to verify this fact microscopically. The researches of MM. Verneuil and Broca have, however, thrown some doubt upon the theory of the cystic formation of these tumours, as also of the denser form generally recognized as the chronic mammary tumour, of which I shall have presently to speak. According to these authors, the glandular nature of the growth within the cell is undoubted; for the pedicle by which it is attached in all cases to the gland, contains evidence of glandular continuity, under the microscope, in the form of long and straight tubes, filled with epithelium. They would, therefore, regard the disease as a variety of *adenoma*, or true glandular tumour, and the cyst as an accidental addition. The fact that, in many cases of sero-cystic sarcoma, the cyst is out of all proportion to the growth, may be held to support the latter view.

Fortunately for the practitioner, whatever may be the true pathology of the disease, its course and treatment are sufficiently ascertained. A disease of adult life, and most frequent in married women, cystic sarcoma is a slow-growing and generally painless affection, giving evidence of the existence of fluid at various parts. The size to which the tumour may develop is well shown in the drawing before you of a patient from whom I remember seeing Sir William Fergusson remove a breast weighing 19 lbs., and whose likeness is given in his *Lectures on the Progress of Surgery*. The fungous protrusion through the skin seen in her case is one of the common features of the disease in its later stages, and this doubtless led many of the older surgeons to confound this growth with other forms of fungus under the common term "fungus hæmatodes." The cystic sarcoma is not, however, a cancerous disease, although it may prove fatal by exhausting the patient's strength and vital powers; there is in connection with it no infiltration of the lymphatic system, nor any secondary deposit. At the same time it cannot be denied that cystic sarcoma has a tendency to recur, as in the case of Sir William Fergusson's already referred to, and in a case recorded by Mr. Cæsar Hawkins, where recurrence took place eight times. This recurrence is in all probability due to the increase and growth of some minute portion of the original growth which has escaped detection at the time of the operation. The obvious treatment, therefore, is to remove the entire breast in these cases, for nothing less will relieve the patient permanently.

I pass on now to a form of tumour of the breast, the glandular structure of which is generally admitted—the *adenoma* or *adenocele*, more familiarly known as the *chronic mammary tumour* of Sir Astley Cooper. This is usually an affection of early life—*i. e.*, between eighteen and thirty years, and occurs more frequently in the single than in the married woman. The tumour is often traced, or supposed to be traced, to some slight injury to the breast, the patient discovering a growth in the organ soon after having sustained some blow on the part. The pathology of this form of tumour is well ascertained, and it consists in a local hypertrophy of one of the lobules or *acini* of the breast, microscopic investigation showing a development of the true gland-tissue, and engorgement of the minute tubuli with epithelioma. At the same time there is a varying development of the fibrous or connective element, and thus some of these tumours in the Hunterian Museum were originally described by Paget as "fibro-cellular," on account of the disproportion of the connective to the glandular structure; whilst Broca describes as a separate class the "adenoma with predominance of stroma." According to Paget, the adenoma is developed from the interior of a cyst; but he remarks that "if all the mammary glandular tumours are of intra-cystic origin, it must be admitted that many of them very early lose the cystic form, and continue to grow as solid masses, for we find them solid when very small." The more recent researches to which I have already referred throw doubts, however, upon the intra-cystic development of these tumours; and as

their close connection with the true glandular structure of the breast is undoubted, though to some extent encapsuled, they are probably not cyst-growths. The progress of the tumour is slow, and for the most part painless, and would probably attract but little attention, were it not for the fear of cancer of the breast so constantly present to the female mind. Although generally single, more than one adenoid tumour may occur in the same breast, as in a single woman now under my care, in whom there are three small tumours at the lower part of the breast. Adenoid tumours have been met with large enough to weigh ten pounds; and occasionally, after being stationary for years, they undergo a sudden and rapid increase. When of large size, they are apt to undergo a process of softening, and then, should the skin give way, an outgrowth or fungus may protrude, identical in its nature with the benign fungus already mentioned in connection with sero-cystic sarcoma.

The diagnosis of this chronic mammary tumour is most important, and in many cases difficult. Undoubtedly, many cases of adenoma have been taken for scirrhus, and many of the vaunted cures of cancer depend in all probability on a similar mistake in diagnosis. The youth of the patient (for cancer of the breast is rare before thirty, which is the favourite period for the simple tumour), the mobility of the growth, the absence of the stabbing pain so characteristic of cancer, the healthy and non-retracted condition of the nipple and neighbouring skin, are all in favour of the adenoma. Another diagnostic sign of some value is the occasional occurrence of a sero-sanguinolent discharge from the nipple when the tumour is situated near that part; but, as already mentioned, this occurs in other growths besides the glandular tumour. The occurrence of cysts in connection with adenoid tumours must not be lost sight of, and their occurrence would render the diagnosis of a simple tumour more easy.

The appearance of these glandular tumours soon after the establishment of the menstrual function, and the undoubted fact that they not unfrequently disappear after marriage, during pregnancy, or during lactation, point to some intimate connection between the occurrence of these growths and the state of the uterine functions; and experience shows that the two organs, the breast and the uterus, have much in common. A transitory hardness and swelling of the breasts is not at all uncommon at the period of puberty, when the menstrual function is first established; and we find a few years later that the same sympathy exists. Patients suffering from adenoma of the breast will be found, on inquiry, to be often irregular, and frequently to be suffering from dysmenorrhœa or from some congested condition of the womb. A patient now under my care, who was sent to me for a supposed scirrhous tumour, which, however, was a rather hard adenoma, is suffering from retroflexion of the uterus, and her breast and uterus are returning to a healthy condition *pari passu*. This is not the time to enter into the treatment of uterine affections; it will be sufficient to say that your attention must be directed to them, and not concentrated solely on the breast.

With regard to the treatment of a tumour of the breast, one great point is to protect it from the anxious inspection and manipulation of the patient, who is apt to keep up constant investigation in order to ascertain its growth or diminution. In recent and slight cases of glandular enlargement, therefore, I simply employ a piece of belladonna plaster to cover the growth and the healthy tissue around it for a short distance. This should not be removed oftener than once a week; and, if persevered in for a few weeks, during which the general health and uterine functions are looked after, no further treatment may be required. Should the disease be of longer standing, however, it may be necessary to apply absorbents directly to the tumour, and for this purpose I prefer the iodide of lead ointment to any of the preparations of iodine, which last are apt to irritate the skin. The ointment may be conveniently applied beneath an opiate plaster spread on leather, and over it pressure may be applied either by bandage or strapping, a pad being used over the growth itself. A convenient method of applying pressure with plaster is to use

two straps, one a little wider than the other, and, having fixed them on opposite sides of the breast, to pass the end of the narrower one through a cross slit in the other, so as to make pressure on the tumour when they are drawn together. Another good plan is the "dove-tailed strapping" described by the late Mr. Maurice Collis, the two straps being cut so as to fit into one another, as shown in the specimens before you.

The good effects of continued pressure in cases of adenoma are undoubted; and in many cases of small size absorption will be produced, and in others a diminution of the tumour may be effected, though it does not follow that the growths may not enlarge again. It is the glandular element which is principally affected by this and other forms of treatment, and a small, hard mass, sometimes left after successful compression, is composed almost entirely of the fibrous stroma of the tumour. Hence, also, the harder and more fibrous forms of adenoma are unsuitable for compression treatment.

When an adenoma is increasing in size, or even when stationary, if it is painful and worries the patient, excision is the best remedy. The operation is a simple one, for it is only necessary to remove the growth, and not the entire breast; and if the tumour be carefully fixed with the fingers, so as to render the skin tense, a simple incision carried down to it at once will allow the mass to be readily enucleated without injury to the breast, if sufficient traction with the fingers or forceps be made on it. The wound usually heals readily, and the patient is at once relieved of her burthen.

The *irritable breast* of Sir Astley Cooper includes two forms of disease: one, where there is neuralgia of the breast without any tumour; and the second, where a painful tumour exists. In the former class the neuralgia depends in all probability on constitutional causes, and may be connected with the uterine function; and appropriate general treatment must be adopted. In these cases it is not unusual to find a general slight induration of the breast, but no distinct tumour. The cases of painful tumour are for the most part examples of chronic mammary tumour which have become painful; but other diseases of the breast of a simple character occasionally display the same tendency. The treatment for a painful adenoma would be the same as for the ordinary form of the disease—viz., sedatives and compression; but should the pain remain persistently, an early removal may be advisable. The possible occurrence of a neuroma or painful subcutaneous tubercle on one of the filaments of nerve in the mammary region must not be entirely overlooked, though its occurrence appears to be exceedingly rare.

In addition to these, which may be termed the common tumours of the breast, there are a few others occasionally met with. Thus, a true fibroid tumour of the breast is occasionally found; and so also the fibro-cellular tumour, of which a good example is recorded by Mr. Bryant in the *Pathological Society's Transactions*, vol. xix. A recurrent form of fibroid has also been met with in the breast; but of this I shall speak in connection with the cancerous growths.

Another form of fibrous disease is that described by Virchow as diffuse fibroma of the breast, or, as it has otherwise been called, benign induration of the breast. This consists in at first a painful enlargement of the whole organ, followed by a contraction of the interstitial fibrous tissue and atrophy of the breast-substance. Virchow compares this to the interstitial inflammation met with in the lungs, liver, and kidneys, and figures a section of a kidney with white fibrous masses in it. Now, we have learnt of late years, and chiefly from the labours of Dr. Wilks, that fibroid deposits in various organs are the result of syphilitic infection, and I am inclined to think that this condition may occur in the breast.

Since writing the above, I have found that, though English authorities are silent upon the subject of syphilitic disease of the breast, yet it has been recognized in France for some years. Lancereaux, in his work on Syphilis (Sydenham Society's translation, vol. i.), recognizes two distinct forms of syphilitic disease of the breast—the diffused or *syphilitic mastitis*,

and the circumscribed or *gummy mastitis*. An Italian surgeon, Dr. Ambrosoli, has also described three cases of the diffuse form of the disease. The gummy tumour of the breast is liable to be confounded with adenoma, and has no doubt been removed for it. A specimen removed from a man by M. Verneuil resembled in its structure a softened encephaloid growth, and exuded a creamy fluid on pressure. Fortunately, in most cases of the kind, the formation of similar tumours in other parts of the body would assist the diagnosis; but where there is evidence of infection of the patient's system (and, for myself, I always believe in such an infection where there is a history of frequent abortions, even without other evidence), a trial should be given to the administration of the iodide of potassium in large doses, and the local inunction of mercurials.

A still rarer form, or at least little recognized form of disease in the breast, is the *myxoma*, or mucous tumour of Virchow, a soft gelatinous growth, often confounded, no doubt, with colloid disease.—*Lancet*, June 17, 1871.

HOSPITAL NOTES AND GLEANINGS.

Pathological Facts indicative of the Conveyance of Disease by Disordered Nerves.—The following observations made at Guy's Hospital, by Dr. Moxon, afford interesting evidence in favour of the transmission by nerves of irritations capable of producing, at their peripheral extremities, grave morbid changes similar to those which have taken place at their centres of origin. We join with Dr. Moxon in hoping that their publication may incite other pathologists to bring forward any facts bearing upon the subject which they may have met with in the course of their investigations.

In reference to these cases, Dr. Moxon says that the fact of nerve-disturbance exciting certain kinds of nutritive changes is illustrated by common examples of the states called "zoster;" by the not unfrequent occurrence of rheumatoid inflammation in the joints of the lower extremities in subjects of paraplegia; by the changes occurring in the retina in intracranial disease; by ulceration of the duodenum, or even of the stomach (of which he has recently seen a marked instance), in burn cases; and by the power of partial division of the fifth nerve to induce ulceration of the cornea, which has lately been reaffirmed. He thinks also that the circumstances and characters of certain other ulcers of the cornea and of the stomach are but phases of hyperæsthesia, and should be treated as being essentially nervous.

Case 1.—While the body of a boy was under inspection, it was noticed that in either side of the chest there was a remarkable band of old pleuritic thickening. This took the course of the third and fourth dorsal nerves so exactly on each side in the parietal pleura, that Dr. Moxon was induced to examine the spinal cord at the point of origin of these nerves for some explanation of so remarkable an appearance. It was then found that at the parts of the cord which gave rise to the third and fourth dorsal nerves, there was an old dilatation of the ventricular cavity. This dilatation would admit a No. 4 catheter, and was two inches long. It was closed at its ends, and the medulla around appeared quite healthy. The wall of this hydro-myelocele was a little thickened. There was no other dilation of the cord's ventricle, nor any other disease of the nervous centres, discoverable. It was scarcely possible to regard this as a mere coincidence. It was no common pleurisy. The peculiarity of its appearance led to the examination of the cord, which otherwise would not have been made. The boy had exhibited no spinal symptoms.

Case 2.—A woman died in the clinical ward of paraplegia. On inspection it was found that a tubercle, of the size of a small marble, occupied and almost destroyed a part of the cord opposite the eleventh and twelfth dorsal intervertebral substance. In the abdomen a remarkable appearance was presented: neither the upper part of the cavity nor the peritoneum of the true pelvis showed any tubercle, but a zone of crowded miliary tubercles extended round the cavity in the peritoneum lining the false pelvis and hypogastrium; there were none on the

viscera. The limitation was remarkable, and the relation of these tubercles to that in the corresponding part of the cord could scarcely be a coincidence. It is known to morbid anatomists that tubercles on the peritoneum, though they prefer the parietal to the visceral layer (except in the case of the omentum), adopt the diaphragm as their favourite seat, and, as a rule, are rather generally scattered; but Dr. Moxon did not recollect having ever before seen such a distribution of tubercles as in this case. Their situation corresponded very significantly with the affected portion of the cord.

Case 3.—A woman had painful paraplegia, with headache, aphonia, and paralysis of the left side of the tongue. The post-mortem examination revealed a free scattering of cancer (soft round-cell sarcoma) in the course of the spine, in the bones. A mass of this cancer grew in the basilar bone, and destroyed the eighth and ninth pairs of nerves on the left side. There was no visceral cancer. The cricoid cartilage was in a singular state: the greater part of its left side was in a pulpy condition. This part was rather sharply demarked from the rest of the cartilage. Dr. Moxon made microscopical examinations on several occasions, but could not determine whether the state of the cartilage was or was not *its* sarcoma. There was some proliferation of the cells, but not very much. The intercellular substance was soft and fibrillar, and reduced in amount. But the appearance was different from that of the other cancer growths; and it was hard to say how far the very unusual circumstance of a development of cancer in cartilage determined the difference of minute structure, or whether some other form of altered nutrition had been in operation. Whichever view were true, it was scarcely possible, Dr. Moxon thought, to avoid concluding that the disease at the root of the eighth nerve of the same side had caused the change. The muscles were atrophied, and the nerves wasted.—*Lancet*, June 17, 1871.

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Effect of Pregnancy on a Fibroid of the Uterus.—A. E., aged 29, married, and the mother of three children, admitted into the Royal Infirmary, Edinburgh, under the care of Dr. Matthews Duncan. Had enjoyed good health up to the time that her second child was born, when she had an attack of what she calls childbed fever. Twelve months after the fever she aborted at the third month, and since then she has aborted twice—at the eighth week and at the seventh week respectively. About four years ago a tumour was detected by her ordinary medical attendant, low down in her abdomen, in the region of the right iliac fossa.

When first examined in the Infirmary she was about five months gone with child; a tumour, about the size of a fœtal head, occupied the right iliac fossa—it was closely connected with the uterus. As pregnancy advanced this tumour was observed to increase in size, and to become soft, which gave it a feeling as if filled with fluid. On returning, five months after her confinement—which was quite natural—the tumour had diminished in size, being then no larger than a turkey's egg. The probe entered the uterus three and a half inches. At this time she expressed herself as enjoying good health, complaining of nothing. A year and a half after confinement the tumour had again increased in size, so as to fully occupy the upper part of the cavity of the pelvis. About this time she missed a monthly period, but at the following period she menstruated very profusely. When examined during the attack of suppression of the menses, the tumour was found to project above the symphysis pubis, to be about the size of the fist, and quite movable; on the other hand, after the menorrhagia, the uterus and tumour were observed to have shrunk into the pelvis.

Remarks.—It is a question of moment to patient and practitioner—one which has been answered both in the negative and the affirmative—whether or not a fibroid of the uterus may disappear spontaneously. On the solution of this question our belief regarding the efficacy of remedies towards promoting this much-desired object will in a great measure be modified. The case before us undoubt-

edly proves that a change in size may be produced by the supervention of pregnancy, that the disease increases with the advent of pregnancy, and that after parturition, when the uterus undergoes involution, the fibroid partakes in the diminution of bulk consequent on this. In the case reported, the varying size of the tumour under different conditions was carefully examined and noted at the time. When first seen, A. E. was pregnant; at that time the tumour was as large as a fœtal head. She did not make her appearance again until five months after confinement, so that an opportunity of judging of the full effect of involution of the uterus on the dimensions of the fibroid was not afforded us. At that time, however, a change in size was to be observed; it was reported as being not larger than a hen's egg. The next report was made eighteen months after confinement; then it had increased in size so as to fully occupy the cavity of the pelvis. During the whole of this period little or no treatment was had recourse to, so that the case illustrates what takes place when this disease is left to the unaided efforts of nature.—*Med. Times and Gaz.*, July 15, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Section of the Forearm by a Saw successfully treated.—H. S. Roberts, of Manhattan, Kansas, records (*The Medical Herald*, Aug. 1871) a remarkable case of this.

A workman in a saw-mill, while reaching into the saw-pit while the saw was in motion, had his right arm caught by the whirling saw, and in an instant almost entirely severed. When seen by Dr. R. he "found, upon examination, that both radius and ulna, with all the extensor tendons of the forearm and surrounding tissues, were divided diagonally across the forearm, from about one inch above the carpal articulation of the radius, to about two inches above the head of the ulna—but that both radial and ulnar arteries with the flexor tendons, and about two and a half inches of the integument, were uninjured." The patient begging most piteously to have his hand saved, Dr. R. determined to attempt doing so. The next morning, having anæsthetized him, "the operation was performed by removing all the spicula, and excising the ends of both parts of the fractured bones, the parts were adapted, and the edges of the wound brought together with the interrupted suture. The arm was then dressed with an anterior long splint—a modification of Bond's—with the hand well extended, so as to allow the ends of the extensor tendons to be caught by the cicatrix, the fingers semi-curved, and all held in place by a few turns of roller bandage. He was then directed to be brought to Manhattan, that he might be under my more immediate care.

"The subsequent dressing was cold water with carbolic acid, which, with an occasional opiate or laxative, completed the medication. A full diet was kept up, and on the ninth of November he was discharged—the wound having healed and the bones apparently united, as there was no indication of mobility or rotary motion to the forearm. Passive motion to the fingers had been begun some time before the case was dismissed. This was directed to be continued, as also that of the wrist.

"I heard from my patient occasionally: that he was having the use of the arm and hand; that he worked at binding grain during harvest, and in the autumn and winter that he used them in chopping.

"I sent a request to him to call on me, as I wished to examine his arm, which he did on the fourteenth of April last, one year and a half after the injury was received, when I found that he had perfect motion at the wrist-joint, almost perfect use of all the fingers and thumb, and, very much to my surprise, that he had the rotary motion of the forearm, but that it was through the medium of a *false joint* at the point of fracture of the ulna. As was anticipated, with each motion of the fingers, the cicatrix moved up and down the arm."

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Exsection of Head of Femur for Morbus Coxarius.—Dr. Sayre exhibited to the New York Pathological Society (April

26, 1871) several specimens of exsection of the head of the femur for morbus coxarius. The first was from a child four and a half years old, who had suffered from hip-disease for two years, at the end of which time it exhibited all the characteristics of the third stage. The disease was caused by a fall down a flight of stairs.

Dr. Sayre saw the case for the first time April 2d, and then opened a large abscess. On account of the size of the latter, the operation for exsection was postponed until the 22d, in order to give the sac a chance to retract. The head of the femur was found lying loose in the cavity, and the unhealthy portion of the cervix was removed by the saw. The child was placed in wire breeches, and in the course of the next twenty-four hours was well enough to be driven out to take the air in Central Park. Since then there had not been an untoward symptom. The point of interest was the speedy and satisfactory recovery of the patient.

A second specimen was from a child five years of age, sent to Bellevue by Dr. Dunster. The case had advanced to the third stage. The head of the femur was removed on the 23d of February. An attempt was made to adjust the wire breeches; but not having a pair to fit, Dr. —— placed the child on its belly, and made a plaster cast of the back and posterior portions of the lower extremities, by which means the hip was kept perfectly steady, and the patient made comfortable.

A third specimen was removed on the 28th of February, from a boy nearly nine years of age. His case had likewise advanced to the third stage. The disease was the result of a fall from a wagon two and a half years before. After the operation the wire breeches were used. The wound was nearly healed ten or twelve days ago. The only drawback was a bedsore on the sacrum and on the back of the heel. There was very little shortening in the last two cases.

Dr. Flint asked if Dr. Sayre had found any connection between morbus coxarius and pulmonary phthisis, in regard to cause and effect; whether, in a word, there was any special liability to phthisis when the matter was so long pent up as it must have been in these cases.

Dr. Sayre replied in the negative, and stated that he had performed in all thirty-nine operations, with eight deaths. In only two was there any tuberculous disease of the lungs found post-mortem. Nine of the thirty-one are living, and have as yet shown no signs of phthisis.—*Medical Record*, August 15, 1871.

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Case of Poisoning from the Bite of a Rattlesnake; Administration of Chloral; Recovery.—J. H., a young man living at Point Pleasant, N. J., had a habit, when he saw a snake lying in his path, of catching it by the tail and cracking its head off. By mistake he "caught a Tartar," in the form of a young rattlesnake, and was bitten through the finger before he could accomplish his purpose. Dr. Robert Laird, of Squaw Village, N. J., saw him an hour afterwards and found him in convulsions, finger and hand swollen, pulse intermitting, eyes glaring and bloodshot, teeth set. He immediately placed a tight ligature about the wrist, scarified and cauterized the wound, and applied a poultice of strong ammonia and tobacco. The patient, before the doctor's arrival, having taken half a pint of whiskey, he gave him a hypodermic injection of morphia. The convulsions still continuing, he pried open his mouth and gave him gr. xx of hydrate of chloral every ten minutes; after taking the fifth dose the convulsions ceased, he sank into a deep sleep of several hours' duration, and afterwards had no more of them. Three days afterwards he was sitting up, convalescent.—*Medical Record*, Aug. 1, 1871.

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Condurango.—We have already expressed our want of faith in vaunted powers of this supposed new remedy for cancer, and all that we have since learned has not tended to weaken our scepticism. Dr. Antisell, of Washington, who has analyzed the article, has failed to discover in it any active principle, alkaloid, volatile oil, or acid, to which active properties could be ascribed, merely a small per cent. (2.7) of yellow resin soluble in alcohol.

The three cases reported by Dr. Bliss (*N. Y. Med. Journ.*, July, 1871), in which he has administered the medicine, seem to us to be very far from justifying his sanguine expectations of their ultimate cure. The editors of the *National Medical Journal* (Aug. 1871) state that they have been disappointed in obtaining for publication at present two reports, now on file in the archives of the Department of State, but that they have "learned through unofficial sources that both reports are unfavourable; in both instances the patients (two) have died." There are few empyrical remedies in regard to which as reliable testimony might not be adduced in favour of their efficacy as has so far been brought forward as to the remedial powers of condurango.

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Medical College of Ohio.—Dr. W. W. Dawson has been elected to fill the vacancy in the chair of Surgery in this institution caused by the death of George C. Blackman, M.D. The appointment is regarded as a most excellent one.

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The Medical World.—This is the title of a new monthly medical journal edited by Reuben A. Vance, M.D., and published by Wm. Baldwin & Co., of New York, and of which the first number was issued in July last. We welcome it to our exchange list.

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Obituary Record.—Died at Cincinnati, on the 19th of July, in the 53d year of his age, George C. Blackman, M.D., Professor of Surgery in the Medical College of Ohio. Dr. Blackman graduated in medicine at the College of Physicians and Surgeons, New York, in 1840. In 1847 he was honoured by an election to the Fellowship of the Royal Medical and Chirurgical Society of London, and in 1853 was appointed to the Professorship which he held at the time of his death. His contributions to medical literature were numerous and valuable; not only did he write for the pages of our periodical literature, but also edited the last edition of *Mott's Velpeau's Operative Surgery*, and translated with annotations *Vidal on Venereal Diseases*. His surgical judgment was sound, his operations well conceived and bold, and his teaching erudite. He did much to extend the fame of American surgery, and in his demise American surgery has met a severe loss.

We regret to learn that Dr. Blackman has left his family inadequately provided for, and are happy to announce that a *Blackman Testimonial Fund* has been formed for the benefit of his widow and children. Contributions to this fund may be forwarded to Drs. M. B. Wright, E. B. Stevens, and W. W. Dawson, of Cincinnati.

FOREIGN INTELLIGENCE.

Chorea of the Tongue from Emotion.—M. Amedee Latour, describing the bombardment of Chatillon, thus speaks of its effect on himself. "During the first days I had tremblings at every discharge of cannon, together with strong and frequent palpitations of the heart and tremor of the hands. My tongue was seized with a kind of insupportable chorea, which, indeed, I have often experienced on the occurrence of vivid emotions, of which, during my life, I have had my share. It is a strange phenomenon, which I have seen nowhere described. The muscles of the tongue are seized with convulsions, which cause the organ to execute irregular movements to the right and left, fix it against the palate, or curve it back on the frænum—keeping it in constant motion, and occasioning a most unpleasant and irritating sensation. Speech is impeded, and articulation painful, so that it is impossible to read aloud, and to converse is a matter of difficulty. These lingual movements are entirely independent of the will, which can neither arrest nor modify them, whatever effort be made. Sleep suspends them; but they reappear soon after waking. This inconvenience lasted during the first week, but after then, as I became accustomed to the noise, the lingual and cardiac muscles resumed their normal action."—*Med. Times and Gaz.*, July 22, 1871.

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Preventive Treatment of Lead-Poisoning.—M. Péligot, director of one of the principal glass manufactories in France,

noticed some time ago that two of his workmen, who were in the habit of drinking a quantity of milk daily, were quite free from symptoms of lead-poisoning, from which the other persons employed suffered extensively. He consequently caused each of his workpeople to bring to the manufactory a quart of milk daily; and from the time when this mode of diet was commenced, there has not been a single case of lead-colic. Dr. Méhu recommends, as a means of removing the fine lead-particles from the skin, the use of baths of hydrochlorate of soda. A solution is prepared by mixing 400 *grammes* (about 13 ounces) of dry chloride of lime, 800 *grammes* of crystallized carbonate of soda, and 10 *litres* of water. This is sufficient for a bath of 44 gallons. The person remains in the bath about half an hour, and rubs with his hands or with a brush the parts where the lead has been deposited.—*Brit. Med. Journal*, July 15, 1871, from *Journal de Méd. et de Chirurgie Pratique*, Mars, 1871.

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Nephrotomy.—Dr. Meadows performed the operation of nephrotomy on July 1st under rather peculiar circumstances. The operation was performed for the relief of a patient who presented the symptoms usually recognized as those of ovarian dropsy, but, on opening the abdomen, the tumour was found to be a large cyst of the kidney. The true structure of the organ had almost entirely disappeared, while the other kidney was apparently healthy. Dr. Meadows, in the belief that the removal of the diseased organ presented the best method of treatment, accordingly applied a ligature, as in the operation for the removal of ovarian tumour. Unfortunately the case proved fatal on the the sixth day from hemorrhage, which took place from the pedicle. The mass was separated close to the spine, and the ligature was applied within an inch of the vena cava. There was not the slightest trace of inflammation anywhere. The gradual and ultimately complete destruction of the secreting substance of the kidney no doubt led to complementary enlargement of the healthy organ on the opposite side, and diminished to a minimum the chances of uræmic symptoms supervening after the operation; but such would likely be the condition in the majority of cases in which it might be advisable to perform the operation of nephrotomy. The cause of death appears to have been purely accidental, and altogether the case lends support to the view that the operation is not so intrinsically formidable as has been generally supposed.—*Brit. Med. Journal*, July 8 and 15, 1871.

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Treatment of Divided Tendons.—In the case of a young man who had received a wound from a billhook on the back of his hand, dividing the extensor tendon of the middle finger, Dr. Bessières had two splints made, curved on the flat: one, the palmar splint, was large enough for the hand; while the dorsal one was two finger-breadths wide. The wound was united by a suture passing through the skin only; the concave surface of the palmar splint was then applied to the hand, and the convex surface of the dorsal splint to the middle finger, which was kept thus (with the aid of diachylon plaster) in a state of extension. At the end of three weeks a little stiffness in flexion remained; and six weeks after the injury the man had complete use of his finger.—*Brit. Med. Journ.*, July 29, 1871, from *Annales de la Société Méd.-Chir. de Liège.*

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Subperiosteal Resection of Joints.—This method has lately been illustrated in a striking manner by Dr. Czerny. This surgeon showed, at a meeting of the Medical Society of Vienna, the elbow-joint of a girl who had just died of pneumonia, and upon whom subperiosteal resection had been performed by Prof. Billroth three years before. The form of the joint had been regenerated, the cartilaginous covering and synovial membrane being clearly apparent, as in a healthy articulation. The shape of the articular surfaces, however, was somewhat different from the normal aspect, and had some analogy with the structure of the knee-joint, as interarticular ligaments had been thrown out, but without interfering with mobility. The insertion of muscles looked

quite natural, and the tendon of the biceps being spread out, gave more power and leverage to the movements of flexion. We have had, on several occasions, to remark that this mode of operating has not found sufficient favour in this country. —*Lancet*, July 17, 1871.

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Perchloride of Iron and Manganese in Necrosis, Fistulous Sinuses, and Hydrocele. —Prof. Marcacci states (*L'Imparziale*) that: 1. Perchloride of iron and manganese, injected into fistulous sinuses, destroys the pyogenic membrane, modifies the state of the walls, and favours cicatrization. 2. In necrosis it acts on the confines of the living bone, stimulating its vessels; so that the detachment and separation of the dead bone are facilitated by the formation of new vessels in the living. 3. In hydrocele it soon modifies the inner surface of tunica vaginalis, which becomes filled with plastic exudation, attended with more or less inflammation, according to the quantity and strength of the injection used. 4. It is not necessary that the tunica vaginalis should be distended by the injection, it is sufficient that the liquid be brought in contact with all parts of the membrane. 5. Very little pain is produced by the contact of the solution, but it is not the less efficacious. 6. A weak solution is sufficient, which should be kept in two minutes. 7. In seven cases of hydrocele, in which the injection was used, hard œdema followed, but was not a serious complication.—*Med. Press and Circular*, July 12, 1871.

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Hydramyle.—Dr. Richardson, in continuing his researches on the physiological action of the light hydrides, has recently succeeded in rendering one of the series applicable for the production of general anæsthesia, and has administered the vapour of it to the human subject, for short operations, twice during the present week, and with marked success. He proposes to call the substance hydramyle. The vapour is so rapid in its action, that, in a case of extraction of a molar tooth, the patient was rendered insensible, the operation was performed, and recovery was completed in fifty seconds. For tooth-extraction Dr. Richardson lets the patient inhale for twenty or twenty-five seconds, and then, although there is still consciousness, he withdraws the vapour. After this, a deep but brief stage of unconsciousness comes on, during which the operation is carried out. The delay in the production of anæsthesia is due to the insolubility of the hydramyle—that is to say, after the lungs are charged with the vapour, time is required for the blood to take up the narcotic and carry it to the nervous centres. The same phenomena may be observed, in a lesser degree, from bichloride of methylene and from methylic ether. For short operations, such as tooth-extraction, the occurrence of deeper insensibility after the inhalation has been stopped is an advantage, and the fact that the insensibility intensifies for a short time, as stated, will have to be specially remembered by administrators. *Med. Times and Gaz.*, July 1, 1871.

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Ozonic Ether as a Deodorizer and Disinfectant.—In a letter to the editor of the *Australian Medical Journal*, Dr. John Day, of Geelong, strongly advocates the employment of this preparation. He states that for the last six years he has kept water-closets perfectly free from all offensive odours, by hanging a piece of sponge against the wall and occasionally pouring over it a few drops of a mixture of ozonic ether and oil of cassia, in the proportion of twenty drops of the latter to an ounce of the former. In the sick-room he found ozonic ether of great value as a deodorizer and disinfectant, particularly for the purpose of purifying the air after the night-stool has been used, when all that is necessary is to pour three or four drops of it on a piece of paper and throw it into the vessel. If used in large quantities it is liable to produce headache. In the proportion of one or two ounces of the ether to a pint of water, Dr. Day employs it with advantage as an injection in those uterine diseases which are accompanied by offensive discharges, and he finds that it not only at once deodorizes the discharge, but acts as a most agreeable sedative. He finds that ozonic ether added to pus gives rise to decomposition, accom-

panied with pretty active effervescence, and that after a time the corpuscles become shrunken or altogether destroyed. May not this fact have an important practical bearing in checking the spread of those diseases that are assumed to originate in the presence of pus-cells with air?—*Med. Times and Gaz.*, June 24, 1871.

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Cotton-wool as a Surgical Dressing.—The surgical novelty of the day in Paris is M. Alphonse Guérin's new plan of dressing wounds. In consists in introducing a quantity of cotton-wool into the stump immediately after amputation, or on any wound whatever, surgical or accidental. The amputated limb—to take this case—is then wrapt round and round with cotton-wool, quite dry and alone; a bandage is then applied, and that is all. The bandage is pressed a little tighter on following days, if necessary, so that there may be a mild compression; but the dressing remains undisturbed till the 20th or 25th day, when, on removing the packet of wadding, a glassful of pus is found within the folds of the cotton, and the wound is discovered quite healed. M. Guérin, amidst the extraordinary mortality which has attended all the amputations done since the beginning of the German siege, has already obtained by this means six successful cases of amputation of the thigh out of nine, whilst all his amputations of the leg are doing well. This has created quite a sensation here in the surgical wards of the hospitals, and Professor Gosselin, of La Charité, and M. Guyon, of Necker, are already experimenting with this method of their colleague of St. Louis.—*Lancet*, July 15, 1871.

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Paracentesis Thoracis in Pleuritic Effusion.—M. Constantin Paul has published, in the *Bulletin de Thérap.* (July 30th, 1871), eight very interesting cases, in which it is plainly evident that early tapping of the chest in undoubted pleuritic effusion is far more favourable than diaphoretics, derivatives, &c. The tapping, as was the case with Trousseau, is not used as a mere palliative, but in view of an eventual cure. M. Paul uses Raybard's instrument, which is fitted to a bag of goldbeater's skin, and has found that no air penetrates the chest.—*Lancet*, Aug. 5, 1871.

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Prediction of the Day of Confinement.—Dr. Duncan, criticizing (*Edin Med. Journal*, 1871) Dr. Ahlfeld's memoir on the duration of pregnancy, says calculation must be empirical. He takes the following method: Find the day on which the woman ceased to menstruate. Take that day nine months forwards as 275 days, unless February is included, when it is taken as 273 days. To this add three days in the former case, or five if February is in the count, to make up the 278 days. He tests this by 153 cases. The prediction should not state the week, but the fortnight of delivery.—*Brit. and For. Med.-Chir. Rev.*, July, 1871.

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Cholera.—The rumoured extension of cholera from Russia into the Baltic provinces of Prussia has very naturally caused alarm lest the malady should again spread to West Europe. The news requires confirmation; and much of the alarm depends upon a mistaken notion of the rapidity of diffusion and direction of progress of the epidemic. One account describes the disease as having made its way in the familiar cholera route from Persia through Russia to the shores of the Baltic; and the Registrar-General, in his last weekly report, writes that "Asiatic cholera (as it was a painful duty to announce early last June) is entering Western Europe through Russia, where, Dr. Zuelzer says, it is fast advancing on the German frontiers. In the second week of this month it broke out in Wilkowyski (a town of Poland, on the road to Konigsberg, west of the Niemen), where 34 deaths occurred within a few days. The epidemic has prevailed in Wilna for four weeks, and from 10 to 15 deaths are reported daily. At its present rate of progress it may reach Germany in two or three weeks."—*Lancet*, July 29, 1871.

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Curious Case of Congenital Malformation.—A very interesting case of malformation of a precisely similar nature occurring in three members of the same family, has lately been seen among Dr. Squarey's out-patients at the Soho Hospi-

tal. The patients are three sisters, aged respectively 26, 18, and 16. The eldest of the three was aware of her abnormality, and came to the hospital to see if anything could be done for her. On examination, the vagina was found to be merely a cul-de-sac, about three inches in length; no os uteri was to be felt, and every method of examination only tended to show that the uterus was absent. She casually mentioned that her younger sister, like herself, had never menstruated. The second sister was accordingly examined; her vagina was a cul-de-sac, about half the length of her elder sister's, and no evidence of a uterus could anywhere be detected. The youngest of the three sisters was also found to be in the same state. This is a very interesting, and, we should fancy, an almost unique case; for although it is common enough for malformations to occur in several members of the same family, they have generally been inherited from one or the other parent, and in the present instance it is difficult to conceive how this could have happened. It would be interesting to know if any similar malformations exist in any of the collateral branches of the family. It is impossible that such can have existed in the direct line. The mother of these patients is, we understand, the second wife of her husband. All her husband's first family, including three daughters, are quite healthy, the daughters having married, and borne children.—*Lancet*, July 29, 1871.

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Murders by Lunatics.—There have been several cases of murder by lunatics investigated lately, and in more than one of these the murderer was known to be insane before the commission of the crime. One instance was that of a man who destroyed his wife, but had been to a Roman Catholic priest a day or two before, who had refused to confess him on the ground that he was not in his right mind. Another case was that of Charles Sleight, a teacher, who murdered a deaf and dumb woman, the matron of the Deaf and Dumb Asylum at Hull. His conduct before the murder had led both his victim and her brother to state that his head was affected. These cases point a moral that the English Legislature is slow to learn. If the persons in question had, at least, been placed under medical treatment and surveillance, with temporary restraint, the crimes would certainly have been prevented, although some medical man might have been made the victim of an action for false imprisonment.—*Med. Times and Gaz.*, August 5, 1871.

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English Aid to France.—Counts de Flavigny and Serrurier, representatives of the International Society for the Relief of the Wounded, and Drs. Ricord and Demarquay, surgeons of the "Ambulances de la Presse," have visited London for the purpose of expressing to the British nation the thanks, not only of the two societies they represent, but also of the French Government, for the generous relief afforded to their countrymen during the late war. They brought with them the Cross of Commander of the Legion of Honour conferred on Colonel Lindsay, the President of the English Society, for succour to the sick and wounded, by the government of France in recognition of the valuable services performed by the society. The medical profession of London entertained the distinguished gentlemen at a dinner at which Sir William Fergusson presided, and at which the most friendly and cordial sentiments were expressed.

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Obituary Record. — Dr. Liegeois, Vice-Professor at the Paris Faculty, and the author of several well-known works on anatomy and physiology, recently died suddenly at Paris. He had accompanied an ambulance during the war as chief surgeon, and the wear and tear of the campaign had much prostrated him.

——, at Brighton on the 7th of July, Thomas Hawkes Tanner, M.D., aged forty-six years. Dr. Tanner is well known in this country as the author of a "Practice of Medicine" of "Signs and Diseases of Pregnancy," of a "Practical Treatise on the Diseases of Infancy and Childhood," and several other works. Dr. Tanner, had suffered for years from slight albuminuria and frequent prostrating headaches. He was an instance of the sad results of overwork of body and mind, of which so many professional men are guilty.

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GUERSANT ON SURGICAL DISEASES OF INFANTS, ETC. 16 PAGES.

CLINICS.

CLINICAL LECTURES.

Clinical Lecture on the Recurrent and Malignant Tumours of the Breast. By CHRISTOPHER HEATH, F.R.C.S., Surgeon to the Hospital for Women, and Assistant Surgeon to University Hospital.

GENTLEMEN: In the present lecture I propose to describe those more serious forms of breast disease which tend to destroy life, either by their constant recurrence, or by involving the patient's system and producing a specific cachexia. I avoid the word "cancer," because it is so difficult to define accurately what is meant by the term. If microscopic evidence alone is to be relied on, many growths will be put down as cancer which the clinical history will exclude from that category; and even the highest authorities are not agreed as to whether undoubted cancer is a local manifestation of constitutional taint, or whether the disease is at first purely local and the constitutional affection a consequence of the local mischief. I should be inclined to group together under the term "malignant" both the forms of disease I have mentioned whose tendency is directly to destroy life, reserving the word "cancer" for those tumours which, in addition to naked-eye and microscopic appearances generally recognized as characteristic of that disease, have a clinical history showing progressive infection of the lymphatic system, leading to secondary deposits and a constitutional cachexia.

The *recurrent fibroid* or *fibro-nucleated tumour*—the chief characteristics of which are a close external resemblance to the ordinary fibrous tumour, but a tendency to recurrence after removal, with a pro-

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gressive softening of successive growths—is occasionally found in the breast, and an excellent example of it has recently been put on record by Mr. Nunn. (*Path. Soc. Trans.*, vols. xviii. and xix.) The tumour was developed in the right mamma, and measured 23½ inches in circumference, weighing 4 lb. 12 oz. after removal. The patient was twenty-eight years old and the mother of two children; and the tumour had grown in two years, ulcerating through the skin at the centre of the growth fourteen months after it was first perceived. There was no enlargement of the lymphatic glands. The tumour was removed in March, 1867; and the patient made a good recovery. The tumour was lobulated and its structure fibrous, with spindle-shaped cells in abundance. Towards the end of May the patient discovered a fresh outgrowth; and on her readmission to hospital in July a mass the size of two fists was to be seen at the site of the original tumour. On July 31st Mr. Nunn repeated the operation, but it was evident at the time that the disease had extended through the intercostal spaces and could not be entirely removed. Fresh sprouting of the growth occurred, and the patient died exhausted on October 23d of the same year. At the post-mortem examination, no secondary deposit in internal organs was found, but the tumour was seen to have invaded the pleural cavity, forming rounded protuberances underneath the costal pleura. Microscopic examination showed the tumour to be composed of filamentous tissue abounding with nuclei, and such as would be generally classed as a fibro-nucleated tumour.

The experience of these recurrent tumours in other situations besides the breast is conclusive as to the necessity for complete and early removal, and therefore nothing less than the removal of the entire breast should be thought of when any recurrence of an apparently simple tumour takes place. Even then the prospects of the patient are as gloomy as in true cancerous disease; for the growth is almost certain to reappear, and to destroy the patient, either by the exhaustion of repeated operations or by involving the pleural cavity.

The *myeloid tumour*, whose characteristic is the large multi-nucleated cells resembling those of the fœtal marrow, is found much more frequently in connection with bones (and especially the jaw-bones) than in the mamma. Doubts have been thrown upon the return of myeloid tumours; but, from what I have seen in the case of the jaws, I have no doubt that myeloid tumours are frequently, though not constantly, reproduced. I have never met with a case in the breast, and must therefore content myself with referring to one recorded by Mr. Paget. The patient was fifty years of age, and had an irregular tumour, between two and three inches in diameter, in her left breast, which had existed for nine months. On removal, it proved to be myeloid; and eighteen months later the patient returned with a large ulcerated tumour in the corresponding axilla, from which she died.

The forms of cancer occurring in the breast are, scirrhus, medullary, and colloid; and their frequency agrees with the order in which I have placed them, scirrhus being more common than medullary disease, and colloid cancer being of rare occurrence.

Scirrhus or *hard cancer* is rarely seen before thirty years of age, and may appear at any period after that, but about fifty is the most common age for the disease to show itself. Unmarried women appear less liable to the disease than married women. Thus, of 260 cases of scirrhus given by Mr. M. Baker, 23 per cent. were in single women, 72 per cent. in married women, and 4 per cent. in widows; and consequently, as Mr. Paget remarks, the percentage among single women is smaller than in the female population generally. Commencing as a small nodule, so painless at first that it is often overlooked for some time, the disease slowly increases in the majority of cases, though occasionally, in what has been termed acute scirrhus, the increase is rapid. Soon, as a rule, pain is experienced in the tumour, of that peculiar lancinating or stabbing character which is often looked upon as pathognomonic; but it must be remembered that absence of pain is by no means conclusive as to

the non-malignancy of the tumour, since some cases of scirrhus run their course with little if any suffering. As the tumour increases, the tendency to involve and drag upon the surrounding tissues is developed: and thus, if the disease is central, the nipple becomes retracted and fixed; or if peripheral, the skin overlying it is bound down and dimpled. Lymphatic enlargement now takes place, the glands along the axillary border of the pectoral muscle being those ordinarily affected, though the glands above the clavicle are also liable to infiltration, particularly when, as Sir Astley Cooper has remarked, the original disease is on the sternal side of the nipple, so that the internal mammary lymphatics become the means of conveyance of the morbid material.

Ulceration of the retracted skin is the next pathological feature, and there is, I think, more variation in this than in any other part of the disease. In some cases the ulceration is so slow, and the consequent discharge so slight, that the patient is able, for months and even years, to conceal her malady from her nearest relatives and friends; whilst in others the ulceration proceeds with rapidity, and extends either widely or deeply — for it rarely does both. The depth to which scirrhus may penetrate is of course limited only by the pleural cavity, perforation of which has been often witnessed; but to the extent to which scirrhous ulceration of the skin may reach there is really no limit save the vital powers of the patient. Thus, a fortnight since, I saw a woman, in very fair general health, with an enormous ulcerated surface on the chest and axilla of the size of a plate, which showed no tendency to become arrested but by the death of the patient.

By the time the skin over a scirrhous breast has become at all extensively ulcerated there will in most cases probably be some amount of constitutional cachexia produced, particularly if enlargement of the lymphatic glands has been an early symptom in the case. Added to this, we have the œdematous and painful condition of the arm due to obstruction of the axillary vein by the cancerous deposit; and the patient is at last worn out with the pain and suffering acting upon a lower vitality. The duration of a case is affected very much by the age and constitution of the patient, its course being slower in the older and less plethoric individual; but the dictum of Sir Astley Cooper may be considered a fair one, taking the average of cases—namely, two years for the full development of a scirrhous breast, and from six months to two years longer for a fatal termination to the case. Instead, however, of running its ordinary course, the disease may become arrested in its progress by a form of atrophy, and the patient may then live for years, and die from disease unconnected with the breast. It is, so far as I have seen, in thin elderly women that this atrophic scirrhus is found; and it may happen, as in a case recently under my care, that the disease will suddenly light up afresh, as it were, and its renewed activity will require immediate operative interference.

In these cases, and also in other cases of scirrhus, particularly (in my experience) those in which the primary disease has been removed with success and without return in the breast, we meet with growths of cancer in internal organs—such as the liver, stomach, or uterus—which may be taken as evidences of a constitutional taint consequent upon or antecedent to the primary disease, according to the pathological creed of the surgeon. Development of cancer in an internal organ is, however, ordinarily so much less painful a cause of death than open cancer of the breast, that this well-known liability to the development of internal cancer ought to form no bar to operative interference in suitable cases. In addition, moreover, to these well-recognized positions of cancer, I have once seen a patient, whose breast had been removed some months before, covered all over with small cancerous tubercles of the skin, varying in size from a pin's head to a medium-sized button; and as there was ptosis with strabismus on one side, together with symptoms of brain disturbance, I have no doubt that a can-

cerous tumour was developed in the brain which pressed upon the third nerve, though I was unable to procure a post-mortem examination.

Medullary cancer is much more rapid in its course than scirrhus, often destroying life in a few months. As might be expected from the differences in structure of the two growths, the medullary tumour is larger, softer, and more succulent than the scirrhous cancer. Its tendency to infiltrate the neighbouring tissues is much greater; and hence, when the skin gives way, it is by a process of sloughing, or very rapid ulceration, leaving a chasm through which protrude masses of soft bleeding cancer, giving the appearance characterized as true *fungus hæmatodes*. Any rapidly-increasing solid tumour of the breast must be viewed with suspicion, and more particularly if the veins running over it are much engorged, and if there is enlargement of the neighbouring lymphatic glands. In this form of disease there is much greater probability of a development of secondary tumours in other parts of the body than in scirrhus; thus not unfrequently patients suffering from medullary breast are carried off by some acute chest attack, when secondary deposits are commonly found in the pleura and lungs.

Colloid cancer is exceedingly difficult of recognition prior to removal — in fact, almost all the examples of it have been mistaken for some other disease. The disease wants the hardness which is so characteristic of scirrhus, and is less rapid in its growth than medullary cancer, the lymphatics being also more slowly affected. A good example of colloid tumour of the breast, with a secondary tumour in the axilla, of five years' growth, is recorded by the late Mr. Price in the 8th volume of the Pathological Society's Transactions, and has appended to it an elaborate report upon the microscopic structure of the growth, by Dr. Andrew Clark.

A section of a recent scirrhous tumour shows a dense white structure, the fibrous nature of which is at once obvious to the naked eye. On scraping it a whitish juice exudes, and this under the microscope shows an abundance of cells, with nucleus and nucleolus, which may be considered to be the so-called cancer-cell. I have the advantage of showing you Mr. Arnott's beautiful drawing of the microscopic appearance of scirrhus, and I cannot do better than quote his own description. The drawing shows "the typical form of hard cancer—*i.e.*, cells of an epithelial type, of varying size and shape, but with tolerably uniform (and usually single), large nuclei closely packed in the meshes of a stout fibrillated stroma, without any visible cellular elements." The proportion of cells to the fibrous stroma it is that determines the character of the growth, for if the cell element preponderates over the fibrous, we have the more vascular form of medullary cancer or encephaloma; whilst if the cells have degenerated, and the fibrous interspaces are filled with a little fatty fluid only, we have the atrophic scirrhus.

There is, then, no special microscopic appearance by which medullary cancer can be distinguished from scirrhus, except by considering it as a whole, and here the naked-eye appearances and clinical history assist us much. The brain-like texture, the great vascularity, and the rapid growth and invasion of surrounding structures, enable us to recognize encephaloma in all cases. It is remarkable, as showing how one form of cancer runs into the other, that the secondary deposits in the axillary glands and internal organs after scirrhus of the breast partake more of the medullary or soft form of cancer than the hard; and, in fact, Mr. Arnott's illustration, which I show you, is taken from an axillary gland. This fact is not so surprising, however, when we find that, as the recent researches of MM. Cornil and Ranvier have shown (by means of nitrate of silver as a reagent), the lymphatics communicate directly with the interspaces in the fibrous stroma of scirrhus in which the cells are lodged. It is not surprising, therefore, that the cell element should predominate in the secondary deposits thus produced.

The structure of colloid cancer is unmistakable, a section showing the loculi filled with gelatinous material of various

shades of colour which are so characteristic of the disease. Microscopic examination shows a delicate fibrous stroma, inclosing in its meshes cells, of which some are round or oval, mononucleated, and having within the outer cell-wall several very delicate concentric lines, giving to the cell somewhat of an oyster-shell appearance (H. Arnott). Other large polynucleated cells are found, and also an arrangement of the stroma in concentric circles, inclosing a number of nucleated cells, and having nuclei interspersed among the concentric layers of tissue.

Few persons in the present day would deny the hereditary nature of cancer, though the late Mr. Charles Moore held that the disease "should rather be styled heritable than hereditary," since he believed that the failures in transmission were more numerous than the occurrences. Yet Paget records that of 322 cancerous patients there were 78, or very nearly one-fourth, who were aware of cancer in other members of their families. And there are many well-known cases of numerous members of one family being affected with cancer, of which perhaps the best example is that recorded by M. Broca, of a family, in five generations, of which sixteen persons out of twenty-six died of cancer in its various forms. General experience may, I think, be fairly summed up in Mr. Paget's words: "Every year's experience in practice among persons whose family histories are known makes me more sure that inheritance is the great power in the production of all diseases that are not of distinctly external origin, and among these of cancer."

The transmission of cancer is not necessarily to the same organ as in the ancestor; in fact, Mr. Paget's tables go to show the contrary to be the rule, for of 61 cases, in only 27 the cancer in the descendant was in the same organ as in the direct ancestor, whilst in 34 it was in a different part. On the other hand, many cases have been known of the same organ being affected in many members of one family—*e.g.*, the Middlesex Hospital case of a mother and five daughters all having cancer of the left breast. A remarkable fact in this case too is that each daughter was successively attacked at an earlier age than the one next above her, the disease appearing to increase in intensity in the children as they were born nearer the time when the disease showed itself in the mother. In other cases, where the disease has been traced through three generations, it has been noticed that the daughter was attacked at an earlier age than her mother, and she again than the grandmother.

Mr. Moore, in his paper on the "Antecedents of Cancer," endeavoured to show that the elder children of a cancerous mother were more liable to the disease than the younger ones; but this is contradicted by the statement given above, for it is evident that the children born nearest the outbreak of cancer in the mother would be most likely to inherit the constitutional taint. Moreover, although it may happen that in a given number of cases the elder children are affected, it must be remembered that, having been born when the mother was in good health, they have had stamina sufficient to live long enough for the cancer to show itself, whilst their younger brethren have possibly died before the disease appeared. Mr. Moore's observation, if correct, that cancer affects the otherwise healthiest members of a family, would confirm this view, for a certain amount of healthiness is essential for the longevity required for the development of cancer in the elder members of a family.

Cancer of the breast is by no means incompatible with pregnancy. Thus in the early part of 1869 I was consulted in the case of a patient, who had advanced cancer of one breast, and also a tumour (doubtless cancerous) of the ilium, who was pregnant. She went her full time, and gave birth to an apparently healthy child, which is now alive and well, and has survived its birth five months. The prospects of a child born under such circumstances one must conclude to be very bad, and he is the youngest of a large family, all apparently in good health. Women have been known even to suckle with a cancerous breast, but such a practice ought not to be permitted by the

surgeon. An interesting example of a scirrhous tumour, complicated with lacteal tumour from this cause, has been recorded by Mr. John Wood. (*Pathological Transactions*, vol. xix.)

The treatment of cancer of the breast must necessarily be influenced by the opposite pathological views already referred to. The surgeon who holds that the local tumour is merely an evidence of constitutional dyscrasia will busy himself with endeavouring to counteract the morbid conditions of the system by medicines, and will be content to leave the local manifestation alone, or at most endeavour to disperse the local mischief. With this object he may employ iodine locally, and internally in the form of iodide of potassium; he may apply bromine in the form of a tincture (as recommended by the late Mr. Colles) to enlarged glands or infiltrated skin, and give the bromide of potassium internally; he may apply cooling lotions or freezing mixtures to the tumour, in order to retard its growth, or may make use of pressure in its varied forms to procure possible absorption; and he will almost certainly be disappointed, and find that the disease makes unmistakable and fatal progress notwithstanding. I say nothing of the various orthodox and quack plasters which are from time to time recommended for the *cure* of cancer, for the subject is beneath notice. At this very moment there is, I know, a foreigner in London who professes to have discovered the long-looked-for "cure-all," and has been allowed, I regret to hear, to try his discovery on the patients of one metropolitan institution, but without any special result.

On the other hand, if the surgeon is convinced that the disease, although the result of hereditary taint, is at first localized in the organ it attacks, but tends to spread in the tissues and affect the system generally through the lymphatics, he will endeavour to rid his patient at as early a moment as possible of the source of mischief, and will thereby, in my opinion, be giving her the best chance of prolonged life and comfort. Of course there are cases in which no judicious surgeon would advise any local interference at all; and it will be convenient, before considering the methods of operating on cancerous breasts, to note what are the circumstances favourable and unfavourable for such interference.

The most favourable concatenation of circumstances is when in a middle-aged patient, of robust health and moderate *embonpoint*, there is a small scirrhous tumour in the neighbourhood of the nipple, which, though retracted, is not ulcerated, while the skin over the breast is healthy and loose, and the axillary and cervical glands are unaffected. From this standard every degree of divergence is met with, and since every surgeon must use his knowledge and experience in deciding as to each individual case, it necessarily follows that differences of opinion will arise in certain cases even among the most distinguished surgeons. There is, however, little difficulty in arriving at the opposite extreme—*i.e.*, the cases which ought *not* to be interfered with; and these by common consent are, rapidly-growing tumours, with great infiltration of the skin, and extensive implication of the glands; cases where other tumours exist, and particularly in the opposite breast; where cachexia is already well established; or where the skin is extensively ulcerated.

The question of local interference in diseases of the breast involves the more important and somewhat disputed question whether the tumour alone, or the entire breast, should be removed. If we believe that cancer has a tendency to spread through the neighbouring tissues, and thus reproduce itself, it is obvious that a complete removal of the organ in which it commences is best, and I am astonished to find that in the present day there should be an attempted reaction in favour of excising the tumour only in cases of cancer of the breast. There may be cases occasionally where the disease is localized in the outer margin of the breast, and is in a very early stage, in which the patient is loth to submit to the more serious operation, and the surgeon may then be justified in excising the tumour, with some of the surrounding structures; but he should for his own

credit's sake explain that the operation is necessarily an incomplete one.

It was pretended at one time that caustics could be applied so as to remove the diseased structures, and leave the healthy; but even the most ardent supporters of that method must allow that the tissues are destroyed indiscriminately by the chemical agents placed in contact with them. The advantages claimed for the caustic treatment by its modern upholders were, the diminution of risk to the patient, the painless character of the proceeding, and the more thorough removal of disease produced by it. With regard to the first point, the immediate danger of an operation (which in the case of the breast is but slight) is certainly obviated, but the after-risks are increased; the patient being liable to exhaustion from prolonged suffering and discharges, and also to the not unfrequent occurrence of inflammatory attacks on the chest, due apparently to the action of the caustic. In respect to pain, there can be no question of the balance being against the caustic, the burning, wearing pain of which is infinitely greater than that experienced *after* an operation performed under the influence of anæsthetics; whilst the removal is really no more complete and thorough than can be obtained from a carefully performed operation, particularly if combined with the use at the time of some chemical solvent of the tissues, as recommended by Mr. De Morgan. The cases most suitable for the caustic treatment are open cancers and cases of recurrent growth, and the applications in most common use are the chloride and sulphate of zinc, made with flour into a paste, which should contain a small quantity of morphia so as to deaden the pain of the application. If the skin is not already ulcerated, it must be destroyed with nitric acid, since it resists the caustic paste. The caustic is best applied on strips of lint, and is pressed firmly against the sore. When the surface has become converted into a gray insensible mass, incisions are to be made through it into the living textures beneath, and into these cuts strips of lint, smeared with the caustic paste, are to be laid. By repeating this operation again and again, the entire breast may be caused to slough out, leaving a large wound, which takes many weeks to granulate up.

In amputating a breast, it is, I believe, most important to remove all skin, fat, and cellular tissue which may possibly contain cancer-cells; and if the growth is adherent to the pectoral muscle, there should be no hesitation in removing some depth of its texture, so as to be well beyond the influence of the disease. The incisions necessary for removing a breast cannot properly be limited to the ordinary elliptical incisions above and below the nipple; for the skin may be involved in other parts, and if any diseased portion is left the operation is useless. Any enlarged glands in the axilla should be removed at the same time; and there is, I find, no difficulty in clearing away all that is necessary in this region, without danger of hemorrhage, by employing the finger freely to enucleate the glands, rather than by dissecting them out with the knife. The free use of a strong solution of chloride of zinc to the whole of the wound is, I think, decidedly advantageous in destroying any remnants of disease in the surrounding tissues; and the occurrence of suppuration during the process of healing seems to be of advantage, rather than otherwise, in the same direction.

The hesitation in removing sufficient skin, which has doubtless rendered many operations on the breast abortive, has to a great extent been obviated by the recent suggestion of M. Reverdin to transplant small portions of healthy cuticle from other parts of the body to the granulating sore left after a free removal of skin. The islands of skin set up by a successful skin-grafting of this kind certainly favour the healing of the wound, and obviate to some extent the painful dragging of the cicatrix so often seen. In a case of my own I was able to transplant five portions of cuticle from the arms to the granulating surface a fortnight after an extensive removal of the breast, and the case did remarkably well.

The results of operations for cancer of the breast vary of course considerably according to the nature of the case and

the previous health of the patient. The operation itself is a remarkably successful one as regards immediate danger to life, although every surgeon must occasionally lose a patient after this, as after every other surgical proceeding, even the simplest. But, in stating the risk to a patient, one has the satisfaction of pointing out that in all probability great relief from immediate suffering will be obtained, and a possible immunity from return in favourable cases. With regard to the prolongation of life as influenced by an operation, professional opinion has undergone a change within the last few years. It was thought by many surgeons that, though comfort was gained by an operation, yet that life was shortened; but the elaborate tables of Mr. Sibley and Mr. Baker, published in the *Medico-Chirurgical Transactions*, show a different result. Mr. Sibley, whose statistics are drawn from the records of the Middlesex Hospital, states that "in the cases of cancer of the breast, those who had been operated on lived 53 months, whilst those in whom the disease was allowed to run its natural course lived only 32 months." Mr. Baker, whose data are drawn from Mr. Paget's experience, says "the average length of life in scirrhous cancer is 43 months when the primary disease is not removed, and 55 months when the operation is performed; whilst in the case of medullary cancer the results are even more striking, being 20 months without, and 44 months, or more than twice the time, with an operation." These results are sufficiently encouraging, and probably the statistics of operation cases may prove more and more satisfactory as both the profession and the public become convinced of the necessity for an early and complete removal of cancerous growths.

With regard to the average date of recurrence of cancer, the greater malignancy of the medullary cancer is again seen, that disease ordinarily recurring within one year, whilst scirrhus does not reappear till the second year, the average time given by Mr. Baker being nearly 14 months for scirrhus, and 7 months for medullary disease. — *Lancet*, June 24, 1870.

Clinical Lecture on Fracture of the Patella. By JONATHAN HUTCHINSON, Esq., Surgeon to the London Hospital, &c. &c.

GENTLEMEN: The patient before us presents a good example of the ordinary fracture of the patella. His right patella has been broken across transversely below the middle, so that the upper fragment is larger than the lower one. In this case the disproportion between the two fragments is greater than usual, the lower portion forming not more than a fifth of the bone. He has now been in the hospital several weeks, and the two portions are very close together, so that he will have, in all probability, a very useful limb. When he first came in there was a considerable interval between the fragments, and his knee was swollen by effusion. The effused fluid was absorbed after a few days' rest in bed, and we then put his limb on a straight back-splint and applied strips of plaster from below the lower fragment upwards, so as to fix this portion of the bone, and other strips from above the upper fragment downwards, so as to bring this portion of the bone downwards to the lower fragment. The limb has been allowed to lie flat on the bed.

I do not purpose now to give you a complete account of fractures of the patella, preferring, rather, to make some remarks on the most important points in the kind of fracture before us, under the headings of *Cause of Separation of the Fragments—Treatment—Mode of Repair.*

In most patients suffering from transverse fracture of the patella, if we examine the bone several hours or a day or two after the accident, we find the fragments separated from one another by a considerable interval, from a quarter of an inch to an inch. We also find, most likely, considerable effusion into the joint. At first thought we shall, perhaps, be inclined to ascribe the separation of the fragments to contraction of the rectus muscle; but that it is really due to quite another cause will be apparent when we examine a little further. We shall probably find, in the first place, that the rectus muscle is not in a state of contraction, or that it becomes so only under the pressure of the fingers or at the patient's will. It is true that

muscles possess a certain small amount of *elasticity* in addition to their *contractility*, and this elasticity, when unopposed, will tend to draw the fragments apart; this force is, however, comparatively unimportant, and for practical purposes it may be safely neglected. We must bear in mind that the patella is firmly attached by its entire circumference to tendinous or ligamentous structures of great strength. Now, when the bone is broken across the fibrous attachments on each side, the tendons of the vasti remain entire, and they are amply sufficient to hold the portions of the patella in place, and prevent their separation, so long as there is no distending force exerting pressure from within. Soon, however, fluid is effused by the synovial membrane, the joint is distended, and what was before a mere fissure through a bony part of the joint-capsule becomes a wide gap. This is the state in which we generally find the knee-joints of patients admitted with fractured patella. In a few cases, however, scarcely any effusion takes place, and it is precisely in these rare cases that the broken portions of the patella never become separated to any appreciable extent. Those cases in which the joint does not become distended, and the fragments are not separted, are the most favourable of any as regards good union; the case will be unfavourable just in proportion to the *amount* and *duration* of the effusion—*i.e.*, the extent and duration of the separation of the fragments. The further the fragments are apart the more difficult will it be to bring them together, and the longer they remain separated the less likely are they to unite by bone.

You will readily see, then, that the principles of treatment are to prevent effusion if it has not occurred, to favour absorption of fluid which has been poured out, and to bring the fragments of the patella into close and permanent apposition.

It is unnecessary that I should go into detail on any but the method of carrying out the last-named principle.

The plan which I invariably adopt, and which has been carried out in the case before us, is to put the limb on a straight back-splint, and by that means bring the lower fragment as high as possible, and by pieces of cross-strapping maintain it there; then to bring down the upper fragment by strapping and firm bandaging as near as may be to the lower fragment, and keep it there by readjusting the strapping as often as it gets at all loose. Many surgeons after doing all this proceed further to elevate the whole limb into the air, with the intention of shortening the distance between the origin and insertion of the rectus muscle. I never adopt this practice, because I believe it to be quite useless, and very uncomfortable to the patient. The advocates of the elevation plan defend it by appealing to a constant state of partial contraction of the muscles, which is supposed to be mainly instrumental in causing the separation of the fragments; and they assert that by lessening the distance between the ends of the muscle they diminish the consequence of this contraction.

I do not for a moment deny that the origin and insertion of the rectus femoris muscle are brought nearer together by elevating the thigh, or by raising the body. I assert, however, that the muscle when left to itself is not in a state of constant contraction; but, on the contrary, that it very soon relaxes completely, and that, therefore, any arrangement for shortening the distance between its attachments is uncalled for. I repeat, also, what I have already mentioned, that it is not to contraction of the rectus but to synovial effusion that the separation of the fractured portions of bone is due, and that it is, therefore, useless to make any special provision for insuring the relaxation of the muscle. I am even of opinion that elevation of the limb may be injurious, for we place it in a constrained position, and I think that muscles when in positions of discomfort are more likely to take on irregular and violent action than when allowed to rest in their ordinary postures.

A few words as to the mode of repair in transverse fractures of the patella. I am inclined to think that bony union is not so rare as it is supposed to be. I have dissected one specimen of union by

bone, and I have seen several cases in which I had not the slightest doubt that bony union had taken place. The last case that I discharged from the hospital was, I believe, one of this kind. I have quite lately seen a gentleman who was treated by his brother, a surgeon, twenty years ago, for fracture of the patella, and whose limb has during that time been in every respect as good as it was before the accident. There is in him a groove across the patella marking the seat of fracture, but on examination I felt no doubt whatever as to the repair having been by bone. The most favourable cases, as I have before mentioned, are those in which no effusion occurs, or in which the effusion is comparatively slight, and disappears rapidly, and which are treated by prolonged rest in bed, these being the cases in which there is little, if any, separation of the fragments. When the fragments of the patella are separated widely, and for a long time, then bony union is very unlikely to occur.—*Med. T. and Gaz.*

HOSPITAL NOTES AND GLEANINGS.

Hereditary Bronze Colour of the Skin Simulating Addison's Disease.—The interest in the following case, under the care of Dr. Jas. Russell, in the Birmingham General Hospital, lies in the contribution it makes to the clinical history of that form of coloured skin which in its general characters imitates very closely the colouring observed in Addison's disease. In the present instance, indeed, the resemblance was so striking that, on a superficial examination, the idea of Addison's disease at once occurred to the mind. Joined to the colouring of the skin, in this case, is to be added the circumstance which generally gives significance to cases of questionable diagnosis in the disease just named—the presence, namely, of protracted anæmia, without any of the usual explanations of that condition being presented by the patient. Of course the occurrence of dark skin in other members of the patient's family at once threw doubt upon the diagnosis, and the doubt was confirmed by the absence of certain peculiarities in the distribution of the colour which are present in Addison's disease. Similarly, the symptoms, whilst coinciding with those of Addison's disease so far as the general evidence of anæmia went, were yet wanting in those special developments related particularly to the circulating and digestive apparatus, which impart so decided a character to the history of true Addison's disease.

C. F., aged 38. The whole of the body and limbs presents a remarkable tint of a rather dusky copper-brown. The colour is perfectly uniform in all parts, excepting on the soles of the feet, where it is nearly, if not quite, absent. The bronzing is very deep over the entire trunk, before and behind. It is also strongly marked on the dorsum of the hands and of the feet, where it is very dusky. The forearms and the knees are deeply coloured; the rest of the extremities more lightly. But the forehead and face, though presenting the characteristic tinge, are the palest parts, with the exception of the palms; the face has rather an anæmic character. The nipples and their areolæ are of a deep brown, but, with this exception, the parts of the body which usually exhibit a deep colour in Addison's disease—the armpits, groins and scrotum—are not, with the partial exception of the latter, more deeply tinged than the neighbouring skin. Moreover, the eyeballs, in place of being clear and pearly, have a curious smoky colour, somewhat intermixed with yellow; the lips and the glans penis are very smoky; the mucous membrane of the lips, cheek, gums, hard and soft palate is simply anæmic, quite without any streak or stain. The patient's hair is everywhere jet-black; his eyes deep brown. He asserted that his skin had always been dark, but that it had become materially darker since his illness began, the change being progressive. The accuracy of this statement is fully established by my friend Dr. Buck, who had watched the patient for the last three years. A change in the opposite direction took place, in a marked degree, in his face whilst in the hospital. There appears no doubt that a dark skin is hereditary in some members of the patient's family on his father's side. His father

had black hair and a dark skin; a brother and sister of his father had also black hair, but a fair skin. He remembers that one of his brothers had black hair and a dark skin; and all his sisters, seven in number, had black hair. He can say nothing further, as he has been away from his family for a long time. Out of seven of his children, five have black hair, and one a dark skin in addition. He knows that his family have lived in the neighbourhood of Pershore, in Worcestershire, for the two generations preceding his own, and that they have been healthy. His illness began seven years ago, with a sudden attack of giddiness and sickness whilst he was working in the fields in the summer-time, probably a mild sunstroke. He lay in bed two days, but from that time he dates gradually increasing debility. Each spring he has been laid by with an attack of weakness, of increasing duration and severity, and on each occasion he has less perfectly recovered. During the past three years he has greatly failed in capacity for work, and during the past year has been almost incapacitated—indeed, the chief question which Dr. Buck had to decide was whether he should be permanently removed to the workhouse. But with these symptoms he has suffered little or not at all from faintness; his breath, though rather short if he exerted himself specially, has never troubled him much, and though he vomited his food during a fortnight, in an attack which he suffered last year, yet he has been almost free from this symptom. His appetite has been variable, frequently voracious. He has never passed worms. During the whole period of his residence in the hospital he has been entirely free from any important symptom; his appetite has been good; he has always been about, and fairly active. For the rest, he is fairly nourished, presents no disease in any organ, his urine is free from albumen and from sugar, he has been quite free from œdema.—*Med. Times and Gaz.*, May 30, 1871.

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1. *Unusual Symptoms of Overloaded Rectum.* 2. *Severe Rheumatic Fever.* 3. *Intense Jaundice.* 4. *Hysteria in a Child.* —The following, under the care of Dr. Ogle, at St. George's Hospital, are instructive:—

1. An old woman, the subject of bronchitis and emphysema, was admitted with pain at the lower part of the abdomen, and dysuria—symptoms to which she had been previously subject. She was suffering from constipation at the time. Her sensations were those of a tumour in the vagina. Enemata which were injected were returned from the bowel. On a vaginal examination being made, nothing was found wrong with the uterus or vagina; but the rectum was found to be crammed full of hardened feces. It felt like a large tumour in the vagina. Persistence in strong purgatives brought away large quantities of feces, and removed the pain and difficulty of voiding urine, which had evidently been due to mechanical obstruction. The bowel would have been relieved with the scoop, had it not been relieved by medicine.

2. A case of *severe rheumatic fever*, of one month's standing, in a fire-brigade man, after exposure to wet for twenty-four hours. At first it was treated by simple effervescing salines, and two-grain doses of quinia; as sickness came on, the latter was discontinued. He made a good recovery under neutral salines, and one or two doses of Dover's powder. Quinia was again resorted to during convalescence. The patient had had a similar attack, with a relapse, eight years previously. There was no heart-complication.

3. A case of *intense jaundice*, of two weeks' standing, in a young woman, following vomiting, which was attendant upon severe nursing night and day. She suffered no pain or abdominal enlargement, the urine was full of bile, and motions wanting. She recovered under taraxacum, and nitrate and acetate of potash, with occasional aperients, so as to leave the hospital with but a slight tinge in a fortnight.

4. A case apparently of *hysteria* in a child aged twelve. She had refused solid food for eighteen months, and had lived chiefly on sweets. On admission she lay cramped up in bed, complaining of intense pain in the abdomen, with her eyes constantly closed or half closed, as if light

gave pain. The expression of pain was always exaggerated when she was watched or spoken to. She was very thin and weak, but no actual disease of any organ could be determined, and the temperature has been natural. Under proper food, with steel and quinia, valerian, and a little stimulant, she has much recovered already. She has been made to use her muscles, and to sit up near the window watching the "row" in the park, and has had shower-baths. She is eating solid food now, and taking cod oil, and is increasing decidedly in weight.—*Lancet*, Aug. 5, 1871.

—

Chronic Inflammation of the Larynx; Impending Suffocation; Tracheotomy; Recovery.—The following case, treated in the Liverpool Royal Infirmary, under the care of Mr. R. Harrison, illustrates the advantages of tracheotomy, not only in affording immediate relief to the distress occasioned by impending suffocation, but by placing the inflamed organ in a state of comparative rest, and facilitating the process of repair which the abnormal activity of the part interrupts.

On his admission, the patient (Henry A.), who was twenty-four years of age, was in a state of considerable distress, arising from difficulty of breathing, which rapidly increased. The symptoms, which had latterly increased considerably, had existed for nearly a year. No distinct history of syphilis could be obtained, though he had two slight frontal nodes. He had never suffered from hæmoptysis, and, beyond some coarse breathing about the apex of the right lung, there were no advanced symptoms of chest complication. He was of a decidedly strumous type. Four years previously his right elbow-joint had been excised by Mr. Bickersteth, with a very good result, the resulting limb being an exceedingly useful one. When admitted, he was so much distressed that he was not able to submit to inspection by the laryngoscope. As several measures designed to afford relief had already failed, and as the obstruction to the entrance of air was clearly on the increase, it was determined, after a consultation, that tracheotomy should be performed without delay. The presence of large veins and a very receding trachea rendered the operation more than usually embarrassing. The patient made a good recovery. The tube was kept in for two months. When the patient was seen about a fortnight later the opening in the trachea had completely closed, the breathing was natural, and the voice was almost completely restored. He was advised to continue the use of cod-liver oil, with iodide of potassium and iron.

In reference to this patient, Mr. Harrison says that, in similar cases of chronic character, delay not rarely results in sudden death from œdema and spasm of the glottis, a condition which in all probability might be averted by early operative interference. When the proper aeration of the blood is interfered with, the time for the performance of tracheotomy has arrived, for the patient's blood is not equal to the repair of the diseased part, while the slightest accident may be sufficient to cause instantaneous death.—*Lancet*, June 10, 1871.

—

Use of the Æsthesiometer in Diabetes.—Prof. Laycock called the attention of his class, at the Edinburgh Royal Infirmary, to the fact that anæsthesia is one of the morbid conditions in diabetes mellitus, and that the defective nutrition and abolished functional activity of the cutaneous glands depended upon a centric neurosis, of which the hunger, thirst, and abnormal productions which characterize the disease are also signs. It is this defect in trophic innervation of the skin which renders diabetic patients so peculiarly predisposed to cutaneous diseases, and upon which the harshness and dryness of the skin depend.—*Med. Times and Gaz.*, May 20, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Malformation. By Wm. P. Overton, M.D., of Cold Springs, Long Island, N. Y.

Mrs. F., æt. 32, mother of six well-formed children, gave birth, July 21st, at full term, to a child with all the intestinal

canal, except the rectum, external to the abdomen. There was an aperture a little to the right of the umbilicus large enough to admit two fingers, through which the bowels protruded.

In every other respect the child was well formed and healthy. It lived three days, during which time it nursed freely, and had several passages from the rectum.

—

Abscess of Appendix Vermiformis Cœci—Recovery.—Dr. KRACKOWIZER stated at a meeting of the Medical Society of the County of New York, that of a number of fatal cases of this affection in his practice, he could relate one of perfect recovery. A young man in Brooklyn was taken with the symptoms of this affection. After a time Dr. Post was called in consultation; and, finding an evident abscess in the iliac fossa, he cut into it, with great relief to the patient. During the formation of the tumour very general and serious peritonitis had occurred, which was controlled by opium. The patient soon recovered, and the wound healed; when, without known cause, unless too much exercise, the pain recurred, and peritonitis was lighted up afresh. Four or six weeks later, the same scene was re-enacted. At this point I was called to see the patient, in consultation, and found general peritonitis, well controlled under the opium-treatment. There was a fluctuating swelling in the right iliac fossa, and I had only to follow the cicatrix of the previous incisions to give the matter exit. The patient was removed to this city, and the wound had nearly healed, when, as he was looking out of a window, a mad bull rushed through the street. Suddenly throwing up his hands, he felt a sharp pain in the old place; was taken down in the same way as before; and a new abscess formed, again to be discharged by incision. One morning, when he had for the fourth time nearly recovered, he noticed, as he threw the wet compress from the wound into the basin, a click which arrested his attention. It proved to be due to the seed of a pear or an apple. From that time the healing was very rapid, and there was no recurrence of the trouble. This was some thirteen years ago. I have since been in the habit of seeing the gentleman from time to time, and not the least trace of any tumour or tenderness can be found — *Medical Record*, May 1, 1871.

—

Prize Essay on Diseases of Children. Open for Universal Competition.—The President of the Medical Society of the County of New York, Dr. Abraham Jacobi, has placed in the hands of its treasurer four hundred dollars, to be awarded for the best essay on "A History of the Diseases of Infancy and Childhood in the United States, and of their Pathology and Therapeutics."

Competitors will send their essays in English, with motto attached, and the name and address of the writer, with the same motto, in a sealed envelope, to the present Secretary of the Society, Dr. Alfred E. M. Purdy, 123 East Thirty-eighth Street, New York, on or before January 1, 1873.

The committee are authorized by the Society to withhold the prize if the essays submitted should not merit it. Austin Flint, M.D., Ernst Krackowizer, M.D., Edward S. Dunster, M.D., committee.

—

Death from Chloroform. — It is announced in the daily papers that a lady died in Brooklyn, in a dentist's office, from chloroform administered by an experienced practitioner. Only four drachms of chloroform, it is stated, were administered.

—

New Remedies. A Quarterly Retrospect of Therapeutics, Pharmacy, and Allied Subjects.—This is the title of a journal, the first number of which appeared in July last. It is edited by Dr. HORATIO C. WOOD, of this city, and published by Wm. Wood & Co., of New York. Its title fully expresses its objects, and under its able editor it will doubtless be a useful publication.

—

The Clinic.—This is the title of a new weekly journal, edited by Dr. JAS. T. WHITTAKER, Professor of Physiology in the Medical College of Ohio, of which the sixth number only has reached us. That

number is well filled with instructive matter, and we welcome our new contemporary to our exchange list, and wish it a successful career.

—

Number of Physicians in New York.—There are in New York City, Brooklyn, and their vicinity, it is stated in the *New York Medical Register* for 1871, 1553 physicians in good standing.

FOREIGN INTELLIGENCE.

Extract of Conium in Inflammation of the Breast. — M. Aldstadter, of Pesth, strongly recommends (*Wiener Med. Presse*, No. 12, 1871) small doses of extract of conium, repeated several times in the course of the day, for the resolution of inflammation of the breast, arising from stasis of the milk in puerperal women, and reports several cases in which striking advantage was obtained from its use. In all instances care should be taken to obtain as pure and active a specimen of the drug as possible.—*The Practitioner*, Aug. 1871.

—

Spasmodic Muscular Contraction—Arterial Compression.—M. Broca had under his care, a few months ago, in the Hôpital de la Pitié, a man who had broken both bones of his leg an hour before his admission to hospital. The muscular contraction was so violent that it was impossible to reduce the fracture. M. Broca thereon employed a method which he had found successful in cases of painful cramps of the lower limbs, viz., compression of the femoral artery. Almost immediately the muscles became relaxed, and reduction was effected with ease. Subsequently, in reapplying the splints, the contraction returned, and was again overcome by the same means. The *Journal de Médecine et de Chirurgie Pratique* for March, in relating the case, says that the simple and easy means employed by M. Broca ought always to have a trial before giving chloroform, which is often done in such a case.—*Med. Record*, Sept. 15, 1871.

—

Phosphates in Pregnancy.—Mr. Metcalfe Johnson, of Lancaster, recommends in the *Med. Times* the hydrated phosphate of lime of the "British Pharmacopœia" as a remedy for the sickness of pregnancy. He gives it in doses of three to ten grains each, three times daily, suspended in water and flavoured according to the patient's taste. In some cases the relief has been so striking that patients have sent to ask for "some of that medicine that relieves the sickness." Mr. Johnson thinks the drug may supply phosphates to the nervous system and also to the embryo, and that if phosphates be not supplied, the child may grow at the expense of the mother's osseous and nervous tissue.—*Doctor.*

—

Deaths from Chloroform.—"We observe with regret," says the editor of the *British Med. Journal* (May 20, 1871), "that two more deaths have occurred this week from chloroform. These frequently recurring accidents afford a significant comment upon the importance of the questions which we have prominently raised concerning the relative mortality of anæsthetics, and the plea which we have urged for a reconsideration of the claims of ether and an extension of surgical practice, in suitable cases, to the nitrous oxide. It is announced in the daily papers that Lieut.-Col. Rogers, R.A., was staying with his brother at Cornwood last week, and, while in the garden at the back of the house, fell over a plant-pot, thereby receiving a compound fracture of the leg and a dislocated ankle. The broken bones were set by two medical gentlemen of Plympton; but, Colonel Rogers not progressing, a third medical man was called in, and it was decided that the leg should be reset while the Colonel was under the influence of chloroform. The latter was administered, and caused almost instant death. No blame is attached to the medical gentlemen."

The second case occurred in the London Hospital. The subject of it was a female æt. 48, who had suffered for a long time from extensive syphilitic ulceration of the leg. She had taken chloroform exactly a week previously, that an attempt might be made to obviate some contrac-

tion about the knee-joint. She had borne its administration well, but it was followed by vomiting, which lasted three days. She had a high temperature, and two rigors, which were probably due to the operative measure. She took scarcely any food up to the day of operation, and had to be sustained by enemata.

On the day of her death (May 3d) chloroform was being administered by the House-Surgeon, who had given it on the former occasion, when, before insensibility had been produced, she made a convulsive movement, and, almost immediately afterwards, *she was seen to turn very suddenly livid.* Her pulse at this moment was felt to beat very rapidly, and the next moment it ceased quite suddenly. She gave one or two spasmodic gasps.

Artificial respiration, sprinkling and flipping with cold water, were immediately resorted to, and a small quantity of blood was abstracted from the jugular vein. There were one or two gasps for breath—probably death-throes; but, although restorative means were kept up for above half an hour, no signs of life appeared. Mr. Couper examined her eyes with the ophthalmoscope, and found the retinal veins greatly distended.

Dr. Sutton remarked that the patient apparently died in consequence of the blood being unable to pass through the lungs. The lungs had the dark red appearance similar to what is seen when death takes place during the collapse stage of burns; and the diminished weight of the lungs showed that they did not contain their normal quantity of blood. The venous system was very much congested; and the comparatively empty condition of the left ventricle, and the appearance of the kidney-tissue (excepting where the veins were distended) tended to show that the arterial system was in a great measure empty.

The evidence tended to show that the patient did not die from asthenia, or, in other words, from failure of the left ventricle, for it was not very flaccid, nor was its cavity full of blood, as is usually seen when death is due to the latter cause. The heart was, however, small, and the muscle very soft, and the microscope showed that it had undergone so-called fatty degeneration to a considerable extent. — *British Med. Journal*, May 27, 1871.

A third case is recorded in the same journal for July 29, 1871, which occurred in the Royal Aberdeen Infirmary, under the care of Dr. Pirrie. The subject of it was a man æt. 37, said to have been of intemperate habits, who was about to be operated on for the radical cure of hernia. Dr. P. ascribed the death to mixed causes, viz.: chloroform inhalation, dread of the operation, and fatty degeneration of heart, the latter being most influential.

—

Sir James Paget —Queen Victoria has just conferred the dignity of baronet upon James Paget, Esq., "Sergeant-Surgeon Extraordinary to Her Majesty and the heirs male of his body lawfully begotten." This announcement has been hailed with universal satisfaction in Great Britain, and we in America partake in the gratification felt at the bestowal of this honour upon one of the most accomplished surgeons and pathologists that have adorned medicine, and one who has done much to advance the science of which he is still a most ardent student.

—

Ununited Fractures.—A volume of 700 pages, illustrated with 102 figures by Bérenger-Férand, on the subject of surgical pathology, is highly noticed in *L'Union Médicale*, 18th August. It is said to be a complete monograph, showing the existing state of our knowledge with regard to the pathological anatomy, etiology, and treatment of ununited fractures.

—

The Female Medical Students in Edinburgh.—We learn from the *Lancet* (July 22, 1871) that at a late meeting of the lecturers at Surgeons' Hall, Edinburgh, it was resolved by a majority to rescind the resolution adopted last year permitting lectures "to female as well as to male students." The lecturers are now, therefore, prohibited from giving instruction to female students either separately or in mixed classes.

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CLINICS.

CLINICAL LECTURES.

Abstract of a Clinical Lecture on Hydrocele and its Treatment. Delivered at King's College Hospital, June 9, 1871, by JOHN WOOD, F.R.S., Surgeon to the Hospital and Professor of Surgery in King's College.

GENTLEMEN: We have had lately in the hospital many cases of *varicocele*, and you have had the opportunity of comparing several methods of treatment which have been followed. In its general pathology, varicocele resembles the diseased conditions of the veins which are found in other parts of the body, and known by the name of *varix*, and the common forms of *hæmorrhoids* or piles. In all these, the coats of the veins are the seat of the disease, which consists essentially in dilatation of their calibre and hypertrophy of their walls, with consequent loss of the function of the valves, which aid circulation of the blood through them. But in each of these different regions of the body where varix is found, there are peculiarities which modify the pathological cause, and require peculiarities of treatment to meet their several exigencies. In true *varicocele* the veins of the spermatic cord which convey the blood from the testicle are the vessels solely affected; and it must not be confounded with varix of the superficial veins of the scrotum, which occasionally occurs. The circulation of the blood through the testicle is probably normally slow, corresponding by the intricacy of its channels with the very tortuous and complex system of tubes which elaborate and transmit the secretion when formed. The

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return of the blood through the spermatic veins is retarded (1) by the intervention of an elaborate plexus, the *plexus pampiniformis;* (2) by their passage through the fibrous inguinal rings and canal, and the muscular cremaster and internal oblique, which closely invest the cord as it hangs over Poupart's ligament; and (3) by the length of the column of blood within them, reaching from the testis to the renal or caval veins high up in the abdomen.

Now, in a perfectly normal condition, the elastic resiliency of the coats of these veins is such that the retardation is effectively controlled and modified.

But slight imperfections are extremely common, and are evidenced in most individuals as an increase in the size of the left spermatic cord. In the surgery of the schools, this is commonly attributed to the fact of the left testicle being placed lower in the scrotum than the right, and to the opening of the left spermatic cord into the renal vein at right angles to the current of blood in the latter, and not, as on the right side, at an acute angle, with a course more parallel to the current in the inferior cava, and more adapted to the efficiency of the valve-action at the acute side of the angle. But a difference in length of column of about half or three-quarters of an inch, or in the angle of junction to the extent of a right angle, do not, in normal conditions and in other situations (where they are common enough), produce undue dilatation of the veins. The other predisposing cause commonly assigned for this greater frequency on the left side, is, in my opinion, a much more powerful one; and that is the position of the sigmoid flexure of the colon across the front of the left spermatic plexus. The sigmoid flexure is the temporary receptacle of the fully formed fecal mass, until the habitual or convenient time for its expulsion has arrived. In civilized society there are frequent and unavoidable conventional causes for delay or neglect of Nature's indications; and constipation and consolidation of the feces is a common accompaniment of artificial modes of living. We have thus greater habitual pressure upon the left spermatic plexus.

But along with these predisposing causes must coexist some other condition lying in the coats of the veins themselves, otherwise the same anatomical, mechanical, and conventional causes would operate alike in all individuals, which is notoriously not the case. Now, in a healthy vein, the middle coat is found under the microscope to contain abundantly muscular fibres of the same kind as those in the arteries. They are arranged both longitudinally and circularly in several successive layers, intermixed freely with white connective tissue, and with a smaller proportion of elastic fibres. In the larger veins of the abdomen, especially, the outer coat also contains, according to Remak, a considerable proportion of non-striated muscular fibres; and this peculiarity extends to a great extent into the spermatic veins. The veins of the lower extremity have thicker coats than those of the upper, and the superficial veins thicker than the deep ones.

If you take a portion of the coats of a vein in a varicose condition and place it under the microscope, you will find that the hypertrophy depends chiefly upon the development of white connective tissue in the outer coat, while the muscular and elastic fibres are proportionately much less developed. The mechanical stress upon the vessels has promoted the development of the merely resisting material, and has atrophied by over-tension the contractile and resilient elements. In some cases, also, I have found a certain amount of amyloid or fatty degeneration of the muscular fibres. At a certain point of the lateral distension, the valves cease to be effective in closing up the tube against regurgitation, and they become finally shrivelled and atrophied from disuse. This promotes the stasis and accumulation of the blood within the vessel, and, longitudinal hypertrophy commencing, results in the coils and serpentine folds which are so characteristic of an advanced stage of varicose veins. We have, in fact, in varicose veins, a

condition, *mutatis mutandis*, resembling, in the thickening of the outer coat and the diseased condition of the middle coat, that of true aneurism in the arteries. There can be no doubt that this predisposition of the venous system is, like so many other diseases, the result of hereditary transmission.

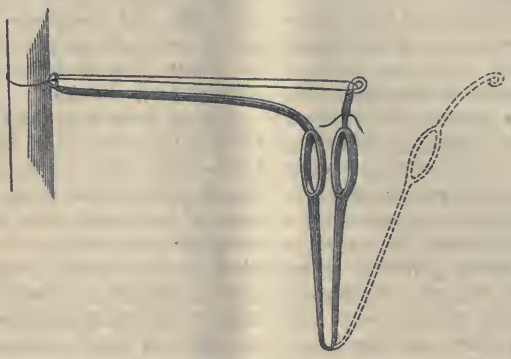
Into the various points of the differential diagnosis of varicocele, I have scarcely time on this occasion to enter. I may, however, mention that the condition which is most difficult to distinguish from varicocele is the presence, in a narrow hernial sac, of an elongated portion of irreducible or adherent omentum, dragged out in the curious and perplexing way in which we sometimes see it, simulating a thickened spermatic cord, or a cyst, or even a testicle, almost perfect in shape. The most certain way of distinguishing them is to mark the effects of position in the recumbent posture, maintained for a length of time sufficient to empty the varicose vessels. Upon an adherent omentum this has, of course, little or no effect. But the coats of varicose veins are occasionally so thick in themselves that a considerable tumefaction remains, even after the blood has passed almost entirely out of them. In such cases, the only resource is in the *tactus eruditus*, which cannot be conveyed by words—the peculiar centrifugal dilating impulse which the cough impresses upon the varicocele, and which is different from the communicated impulse of an omental hernia. When the omental hernia is reducible, no difficulty should arise. The means of distinction given in books is to reduce the swelling while the patient is in a recumbent posture, and then placing the finger firmly upon the superficial ring, to let the patient assume the erect posture. If it be a hernia, the swelling does not return; but if it be a varicocele, it does so in a short time, but gradually. Fatty developments in the cord are usually persistent under any position; and, like omental hernia, doughy and inelastic to the feel, and, unless confined to so high a position in the inguinal canal as to contraindicate varicocele entirely, have not usually a cough impulse.

Varicocele is often attended by an amount of pain totally disproportional to the size of the tumour. It is probable that this proceeds from pressure or tension, during the initiative stages of the disease, upon the spermatic plexus which surrounds and embraces the veins, and supplies branches to their coats. The pain usually affects, also, the groin of the same side, and sometimes reaches the lumbar region, by an effect upon the renal plexus, from which part of the spermatic plexus is derived.

In many cases, also, there is a morbid fixity of the attention of the patient to his condition, which is sometimes indicative of serious mental derangement. Atrophy of the testicle may be coexistent with varicocele, and in most cases is the result of the impaired nutrition consequent upon the continued congestion which results from the varicocele, as in the condition called varicose eczema in the legs. In most cases, an operation, if applied early enough, will prevent this atrophy; but sometimes the wasting goes on, and may even be considered by the patient as the effect of the operation. He should always, therefore, be informed beforehand of this possible result.

The treatment that you have seen lately carried out by me, gentlemen, is an application of the principle of metallic wire pressure, applied subcutaneously, and with very little disturbance of the parts, by means of a new instrument which I have devised and carried out, with the help of Mr. Matthews, for the application of a continually acting spring traction. The very ingenious apparatus of M. Ricord was previously the most successful attempt to effect the same results; but it acted upon a silk or hempen ligature, applied in a peculiar manner round the vein, and had not the advantage of metallic pressure. This apparatus is ponderous, unwieldy, and requires screwing up afterwards. I have made many attempts, gentlemen, as you know, to obtain the advantages of continuous and unintermitting wire-pressure, so applied and self-acting that no subsequent interference by the surgeon or any screwing up of the apparatus, should put the

patient to all or more of the pain of repeating again and again the original operation; so arranged that the wire could be at any time disengaged and removed with little or no pain to the patient, or disturbance of the parts; and so simple as to be easily managed by anybody, easily cleaned, and not liable to get out of gear. Well, the outcome of so many trials seems simple enough when you look at it, as did the celebrated egg-trick of Columbus. It is a strong, steel, highly tempered spring, acting like the spring of a pair of dissecting forceps. One limb carries at the end a thin round steel shaft, about an inch and a half long, which ends in a transversely oval and obliquely placed eye, for transmitting the wire snare or loop which encircles the vein. The other limb terminates in an arm or hook, round which the ends of the wire are twisted and fastened. The rings upon the two arms are for the purpose of giving a firm hold to the finger and thumb while compressing and closing the spring (as shown at the middle of the figure), till the ends of the wire are fastened upon the upper limb. The dotted lines at the outer part of the figure show the upper arm when at the extent of its action; and its distance from the closed arm shows the extent of transit of the wire to be more than is necessary to drag it clean through the inclosed vein. The steel shaft which carries the wire is pressed down close upon the vein through the puncture, at which the ends of the wire emerge. The puncture is left uncovered for the escape of any discharge which may form, for which the shaft of the instrument and the wire form a direct conductor. I have found it better, also, so to arrange the punctures that the one through which the instrument passes shall be the most depending point in the track of the wire, so that no accumulation of discharge is possible within the wound. This is a point of much importance to obviate any subsequent trouble. It is also important, as I have proved experimentally, to provide that no pressure or obstruction be placed at the puncture through which the wire emerges;· but that allowance be made for any swelling of the parts around which may occur. This is effectively provided for by the length of the steel shaft, and the elevation of the counterpressure from the surface of the wound. Any instrument which covers over, obstructs, and presses upon the puncture in the skin, is objectionable for this reason. In large cases, of course, a larger instrument and a stronger spring may be required. In small cases, a spring of twisted steel wire, somewhat like that of a mousetrap, has been found sufficient. Such an instrument I have found to act admirably in cases of varicose saphena.



The wire used is the best and toughest iron wire, as thin as may be judged strong enough to bear the tension of the spring. It is first dipped in carbolized oil, and passed by means of a long needle in the ordinary subcutaneous way, first under the veins, and then back again

over the veins, between them and the skin, entering, re-entering, and emerging through the same cutaneous apertures. The ends are then drawn as taut as possible; the loop sinks through its puncture into the tissues out of sight; and the spring-tractor is finally fixed by passing both ends of the wire through the oval eye, pressing down the spring firmly between the left thumb and forefinger, winding the wire tightly round the hook, and fixing it there.

In most of the cases lately in the hospital, all of them men under the age of forty years, the spring-tractor was kept on for a week or ten days; but in one case, which is now in hospital under treatment, we had to deal with a very large varicocele, reaching down behind and below the testicle. In this instance, a pair of tractors and wire ligatures were applied, one above, and the other below and behind the testicle, and kept on for fourteen days. In none of these cases have the patients complained of any pain worth speaking of; there has been little or no discharge, and no formation of pus; and they have been discharged cured a few days after the removal of the wires. In the last-mentioned case, some time after the instruments and wires were withdrawn, we had a very small superficial abscess, but it occurred in a different part of the scrotum, towards the opposite side, and resulted, apparently, from the pressure of the cross strapping used to sustain the scrotum. It was opened by the house-surgeon, and gave thenceforth no more trouble.

In all the cases we have had a very great amount of thickening from fibroid deposit in the track of the wire ligature, producing a great amount of lateral support to the weakened vessels, and persistent for a considerable time, as you may have seen by the patients who have returned for inspection, at a period of many months subsequent to their discharge from the hospital. In patients whom I have seen years after a precisely similar operation, effected by means of an instrument acting with wire in the same manner, but upon a different principle, which I then employed, the veins have remained quite impervious, with a hard, firm, constricted portion, or indurated ring, at the site of the operation. In most of the cases, I have withdrawn the wire before it has quite cut through all the included tissues, and the results have been equally good as in those in which the loop has cut its way clean through. I believe, therefore, that it is not always necessary to prolong the cure by waiting for this result, inasmuch as a great deal of fibrous tissue, not forming part of the venous channels, is necessarily included in the ligature, and often prolongs the process of separation after the veins have been entirely occluded. A dense, hard, and resisting ring of fibroid tissue is formed around the veins by the action of the ligature, which resists the pressure of the blood outwards, and prevents redistension. And not the least of the advantages of the apparatus I have described is the power that it gives us of withdrawing the ligature without pain or disturbance, when it it evident that the desired result has been arrived at, as ascertained by the deposit of fibrin and the small length of the wire yet remaining engaged in the tissues.

In this method, gentlemen, it appears to me that we have all the advantages of subcutaneous treatment and thin metallic pressure, combined with a continuous and equable traction, by which we obtain a division of the diseased veins without danger of hemorrhage, with little or no pain to the patient, without the repetition of a most excruciating process of tightening or screwing up the ligature upon the inflamed tissues; and we get, in a short course of treatment, complete division or occlusion of the veins, no open sore (which, in such cases, is very often very slow to heal), and no suppuration which may endanger the entrance of pus into the veins. And this is combined with the power of disengaging the wire compress; with little pain and no disturbance of the parts, which might set up the process of disintegration of the clot or suppuration of the vein; and with a simplicity of construction and ease of manipulation which leaves little to be desired in the way of improvement.—*Brit. Med. Journ.*, Sept. 16, 1871.

Lecture on the Treatment of Smallpox. Delivered at Homerton Fever Hospital. By Alexander Collie, M.D., Resident Medical Officer.

In the mild variety of smallpox treatment is not of importance. "*Il ne faut que demeurer en repos.*" The patient should be kept in bed until crustation is completed, should be fed on light and easily digestible food, and should have his linen changed daily and fresh cool air in abundance. No drugs will be required, except perhaps a purgative pill or a little castor oil. In the black smallpox all treatment is useless, and our efforts should be directed simply towards palliating the patient's sufferings. Cold water will probably be most grateful, and that ought to be given freely. An egg beaten up in a little whiskey-and-water will relieve sensations of exhaustion, but beyond this our art is powerless. Large doses of stimulants are simply wasted. In the severe or confluent smallpox, however, treatment is of the highest importance. Here our management will sometimes determine the result. The patient should be placed in a large, well-ventilated room, a room with opposite windows if possible, and these should be kept open by night and by day and in all seasons. If the weather is very cold, keep a good fire in the room, and let the patient have an extra blanket, but keep the windows open; and if the weather is mild, treat the patient absolutely in the open air. Nothing is of so much importance as pure air, and that in unlimited quantities. In this hospital we have kept our windows open constantly by night and by day throughout the months of February, March, April, &c.; and this has been attended with the very best results, for our mortality is the lowest of all the smallpox hospitals in London, and we were receiving our patients from the same sources, and some time before the epidemic reached its height. Including every death, our mortality is only 14.6 per cent.; and if we were to strike off those who died of sequelæ, and those who died six, twelve, and twenty-four hours after admission, it would be considerably less. Up to July 22 the mortality in the different hospitals has been as follows: Hampstead, 19.1 per cent.; Stockwell, 17.6; Homerton, 17.1; Mrs. Gladstone's Smallpox Hospital, 17.1; Stockwell Fever Hospital, 15.5; Homerton ditto, 14.6.

The patient's bed may consist of feathers, or a hair or flock mattress; and there ought to be two beds in the room, in order that the patient may be changed from one to the other, and the bed made —a matter of great comfort to a sick person. The sheets ought to be of the finest and softest material. The coverings should be light, and all curtains should be removed. The room ought to be absolutely cleared of rugs, carpets, cushioned chairs, wardrobes, pictures, and everything which might harbour a particle of dust or a smallpox scab. Secure two competent and efficient nurses, one to act by day and the other by night, and remember that, usually, relatives make bad nurses. Inquire first about the bowels, and, as a rule, give a gentle purgative; but do not purge.

Do not place your patient on low diet. That a patient about to undergo the exhausting labour involved in an attack of smallpox should be starved is, in my opinion, of all medical absurdities the most absurd. Your patient will not be able to take food in the same form as in health, but he must and should have the same in quantity, if not, indeed more, although in a different form. Let your patient have milk in abundance, as many raw eggs beaten up with a little whiskey as can be stuffed into him, beef-tea, arrowroot, sago, tapioca, &c. Ordinary tea and coffee, of moderate strength, you will find pleasant stimulants, and these should be given, remembering, however, that if given in too large a quantity they have a tendency to prevent sleep. To relieve thirst, cold water is usually the best and the most pleasant to the patient, and he ought never to be refused this. You will find, however, amongst some nurses and patients' friends a decided objection to giving much cold water. Always combat this notion. There is nothing more pleasant to a parched mouth and a dry tongue than pure cold

water. Effervescing drinks, such as lemonade, soda, and potash waters, are very refreshing.

For heat of skin the patient may be sponged with tepid water two or three times daily. Indeed, in all cases of smallpox the whole body should be sponged daily. If there be restlessness or sleeplessness, the following, repeated in half an hour, if needed, will be found of great service: Tincture of opium, fifteen minims; spirit of ether, fifteen minims; camphor water, one ounce. Or, what we have often found to succeed when drugs proper failed, was two or three ounces of whiskey in warm water, and a little sugar. Of course the dose must be modified according to age and sex; but in restlessness, sleeplessness, and delirium we have found this latter most useful. In the early stages, with the last-mentioned exception, avoid stimulants as a rule; but remember them about the tenth day, when the patient's powers will be taxed to the utmost. There is no special drug to be given; and I would advise you not to bother your patients much with mixtures. Feed them. If salivation be present, you had better let it alone; and be careful of giving sedatives, as the mouth and air-passages become more or less choked up with the saliva—a condition which would be very serious if bronchitis were also present. Soreness of the throat is always more or less troublesome. Oleaginous and mucilaginous drinks, and black-currant jelly, may be given as an amusement; but the only remedy is time and patience. Try the following, which we have found beneficial in this condition: Tincture of perchloride of iron and glycerine, of each thirty minims; three times a day.

Towards the eleventh day look out for laryngitis; and when it occurs, wrap a large linseed poultice round the throat and keep it there, changing it three or four times in the twenty-four hours. Raise the temperature of the room, and surround the patient with an atmosphere of steam. Avoid antimony, mercury, and such like; and do not exhaust your already exhausted patient with emetics. I suppose I need hardly caution you against bleeding. Warmth, steam, feeding, and some stimulant are in my opinion the best and safest remedies. If the difficulty of breathing increases, and you perceive commencing exhaustion, perform tracheotomy at once, unless there be reason to believe that the patient will die of smallpox. If there be no reasonable chance of recovery from this, a prolongation of a few hours is only a prolongation of human suffering. Still, one can readily imagine cases where prolongation of life for an hour, or even for a few minutes, might be of the greatest importance. Of three tracheotomies performed here one recovered.

Delirium is present in some stage of the disease in a considerable proportion of cases, and it requires very careful management. It is usually most violent and dangerous in the early stage of the illness. See that your patient is not left alone for a moment, otherwise you may find him through the window, and on the street below. Delirious patients are very cunning, and watch anxiously for the absence of attendants in order to carry out their wishes. They bear contradiction badly, therefore see that the nurse does not oppose them, or argue with them. If a patient will get up, let him do so, and walk him about the room or into the staircase, and after that you will probably find him glad to get to bed again. Humour him always if you can, and do not treat him on the supposition that he is a poor stupid fool, for whom any kind of story will do. Remember that such patients are very cunning, and that their *reason* always remains intact. The objective world, as it presents itself to their consciousness, is distorted, but their reasoning on it is always sound. Always agree with your patients, therefore, and try to convince them that you are taking the necessary steps to accomplish what they wish, or to prevent what they fear. Try to discover the way in which the objective world presents itself to their consciousness, remembering that in the highly irritable condition of the nervous system present in delirium, objects are far more vividly conceived, and produce a much stronger impression than they do in

health. If your patient thinks he is going to be murdered, and that his nurse is in league with some one for this purpose, do not try to convince him to the contrary. You will only irritate him, and produce a conviction in his mind that you are in league with his enemies. Send away the nurse; put your patient into another room; command absolute darkness and absolute silence, and in the majority of cases this will succeed. Beware of using force, or of tying your patient down. I have again and again seen slightly delirious patients driven frantic by this means. Patience, gentleness, and firmness will almost always succeed, but above all things gentleness. Remember you can never handle a sick person *too* gently, nor speak to one *too* softly. To a shattered or highly sensitive nervous system, the slightest sound, the faintest light, the gentlest touch, are sometimes almost unbearable. If, therefore, a patient will get out of bed and walk about, will persist in throwing about his arms and legs, let him do so. It is far better that he should exhaust himself than himself and one or more attendants. Of course, if suicide is attempted in any form, force must be used; but proper nursing will never give an opportunity for an attempt of this nature.

The prevention of pitting has exhausted the ingenuity of all who have thought about it. To assist in preventing this deplorable result, common olive oil should be used; but all means employed for this purpose fail where most wanted. In the severe cases nothing will prevent pitting; and I would not advise you to try any of the ordinary methods. To use nitrate of silver effectively in confluent smallpox would give rise to so much irritation as to endanger the patient's life. The famous emp. Vigo is, in my opinion, a humbug. Tincture of iodine, calamine, with olive oil, sulphur ointment, &c., have been employed with more or less success as the practitioner has argued *ergo propter* or *ergo post*. I believe you will only annoy your patient by using them.

About the eleventh day you may find diarrhœa troublesome; but I would not advise you to interfere with it unless it is excessive or clearly weakening the patient. A little castor oil may be necessary; and in most cases I should prefer to try this first, as patients are usually constipated in the earlier stages of smallpox, and diarrhœa is sometimes an indication of the presence of irritating substances in the intestine. If castor oil fails, try the following: Dilute sulphuric acid, fifteen minims; tincture of opium, five minims; water, one ounce; four times daily. Along with this may be given a starch-and-laudanum enema, with fifteen, twenty, or thirty drops of the latter, according to the age. This will succeed in the majority of cases; but when it fails, recourse must be had to the more powerful astringents. See that your patient is not taking too much whiskey, as that sometimes causes diarrhœa.

Just about this period bronchitis, by itself or with pneumonia, may arise. Wrap your patient's chest in a blanket or in cotton-wool; and if you think he requires a drug, the following is a good one: Carbonate of ammonia, five grains; spirit of chloroform, fifteen minims; tincture of squills, ten minims; infusion of senega, one ounce; every three, four, or six hours.

Stimulants may now be useful. We avoid rules on this subject. In short, we always think more of the person, his history and constitution, than of the disease. In other words, we treat a *person* in a diseased condition, and not merely a disease. I will not speak very dogmatically on the question of alcohol; but I am quite sure that, in large doses, it sometimes does well. In small doses, such as an ounce or two, to help a raw egg down, or with a little hot water to produce sleep, it is always useful; but I think that in some cases it actually determines recovery. Ordinary physiological rules, coupled with the age and habits of the patient, must be the chief guide. If he has been accustomed to his daily or nightly glass, by all means let him have some stimulant all through.

The most hopeless of complications or sequelæ is pleurisy. We have employed with some success the following treat-

ment: Tincture of iodine painted over the affected side; cotton-wool wrapped round the chest and throat; a mixture containing fifteen minims of tincture of muriate of iron and thirty minims of spirit of nitric ether, in an ounce of water, three times daily; with stimulants in moderation, and good feeding. Always feed, whatever may be the complication. Erysipelas requires simply feeding and tonics; as local applications we have invariably used fine flour and poultices. We have only had one fatal case.

With regard to abscesses, early opening, tonics, feeding, and stimulants should be the treatment pursued. The following is an admirable tonic: Two grains of sulphate of quinia, twenty minims of tincture of muriate of iron, and fifteen minims of spirit of chloroform, in an ounce of water—thrice daily.

Crusts should not be allowed to remain about the nostrils and mouth, where they poison the air which the patient must breathe. They should be carefully removed as they form, and a stream of carbolic acid lotion kept running over the part which is being removed. Air cannot pass over decomposing fetid matter without being more or less contaminated, and I believe this source of contamination is not sufficiently recognized. Always remove scabs under which pus is forming; and at this period see that your patient is bathed, which, if properly managed, may be done without producing exhaustion. It greatly adds to a poor creature's comfort to have a quantity of stinking matter washed away. A little carbolic acid may be put in the bath.

When the patient begins to convalesce, and also for some time during the convalescence, he is often irritable, and generally uncomfortable. In this condition we have found the following very useful: dilute sulphuric acid, fifteen minims; tincture of opium, five minims; water, one ounce—three or four times daily. It relieves irritation, soothes the mind, and helps on the appetite.

Be particular throughout that your patient's linen is frequently changed. In some cases this may be an hourly instead of a daily necessity. Also see that he does not always lie upon his back, but that he is frequently changed, so as to avoid too constant pressure on particular parts. In severe cases procure a water bed at once. By good nursing, let me repeat, almost all bedsores might be prevented, and to their prevention we ought to look most carefully. Do not believe your nurse that your patient is dry and all right; look for yourself and see. Receive no information from nurses or friends which you may acquire from your own observation. Accept nothing on credit which you can see for yourself.

For hemorrhages from the mucous surfaces there is no special treatment. If it is severe, add to your stimulant, and take care that your patient does not get out of bed to stool. Indeed, in severe smallpox, you should never allow your patient out of bed to stool after the seventh day of the disease. Insist on the bed-pan.

Orchitis, gonorrhœa, and arthritis sometimes require warm poultices and mild astringent lotions, but these are usually sufficient.

Such is the treatment we have employed. To sum up: air, cleanliness, feeding, stimulants in moderation, sedatives, and tonics are, we believe, the best treatment for smallpox.

One important question may be here answered—viz., when a smallpox patient may be considered free of danger to his neighbours? This, in reference to the public, is a most important question, and one which requires an accurate answer. We have thought over this very carefully, and we believe that we have arrived at an unassailable conclusion. It is a truism to say that a healthy man cannot give to another a contagious disease; for the question at issue is, when and how a person may be certainly recognized to be in a state of health. Now, you know the ordinary signs of health: a certain temperature, or rather range of temperature, a quiet pulse, a clean tongue, a clear mind, &c. When you find these conditions in a smallpox patient, he is in a state of health. But—and this "but" is very important—certain products of disease remain for an indefinite time attached to the body.

These are the scabs, and the scales which follow them. When these are quite gone, your patient well washed, and clean clothing put on, you may send him anywhere without let or hindrance. The practice here has been that, as a patient is ordered out of bed, he has a bath, and this is repeated every second day until he leaves the hospital. It facilitates the removal of the scabs. No person has ever been sent out of this hospital with a smallpox scab or scale.

I have but a word to say about children's heads: they are most aggravating. Shave, poultice, until removal of the scales, then use tar or oxide-of-zinc ointment, the former being preferable, and give the following: Cod-liver oil, one drachm; iron wine, two drachms: three times daily.—*Lancet*, Sept. 30, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Frozen Beef-Essence.—Dr. H. B. Hare states (*Phila. Med. Times*, Oct. 16, 1871) that in a case of scarlet fever in a child, the patient could not be induced to swallow the beef-tea which his condition required. As he took ice with avidity, the father suggested that if the beef-tea were frozen he might then be induced to take it in that form. The suggestion was carried out, and the child took the frozen beef-tea readily. This expedient may in many cases be advantageously resorted to.

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Criminal Abortion.—Dr. Finnell exhibited at the meeting of the New York Pathological Society, Sept. 13, 1871, the uterus and appendages taken from the body of a young woman, Alice Bowlsby, who died by abortion. The case was the one associated with "the great trunk mystery." The young woman, finding herself pregnant, came to New York to have an abortion produced. She entered the house of one Rosensweig, who performed some operation upon her which resulted in her death. She left her home on Wednesday, and probably on the same day the abortion was produced. On the following Saturday evening her remains were found packed in a trunk at the Hudson River Railroad depot, checked for Chicago. The autopsy was made by Dr. Cushman, to whom Dr. F. was indebted for the specimen. The body was far advanced in decomposition. On opening the abdominal cavity there were marked evidences of metro-peritonitis; the uterus was enlarged and gave other signs of having contained a fœtus; the mucous membrane of the cervical canal was torn in several places, as if by some blunt instrument. He, Dr. F., thought it rather remarkable that death should have occurred so rapidly in this case, and that decomposition should have been so far advanced so short a time after the operation.

Dr. Rogers remarked that the facts connected with this case were curious and interesting. This young woman was said to have left her home on the afternoon of the 23d; that while her mother went home she took a détour to New York. Nothing more was heard of her until Saturday, the 26th—three days after. She was found in a trunk, in such a state of decomposition as to attract the attention of the people employed in the depot. It would seem that she must have been dead at least twenty-four hours to have arrived at that state of decomposition. Supposing the operation was performed on the night of her arrival, she must have died on the morning of the 25th, to have given time for the decomposition to have advanced. It was altogether probable that she died within twenty-four hours after the operation, and taking that apparent fact in connection with the alleged cause of death—metro-peritonitis—it made a very unusual case, more especially when the lacerated condition of the tissues about the neck of the uterus was taken into consideration. The question might be agitated whether the woman did not die during the operation, from mere shock, or whether it were not possible that a uterine vein had been opened and air entered the circulation.—*Medical Record*, Oct. 2, 1871.

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Medical Society of the City of Wheeling and County of Ohio.—This Society, at its

meeting on the 6th of October last, elected the following named gentlemen as officers for the ensuing year: President, Dr. Wm. Jourdin Bates; Vice-President, Dr. Richard Blum; Secretary, Dr. S. L. Jepson; Treasurer, Dr. John C. Hupp; Board of Censors, Drs. R. H. Hazlett, E. A. Hildreth, and John Frissell. The Society meets on the first and third Friday of every month.

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Chicago Medical Colleges.—We are happy to learn that the Chicago Medical College and Mercy Hospital entirely escaped damage in the dreadful conflagration which recently devastated Chicago, the fire not extending to that portion of the city in which they are situated. We lament to learn, however, that the Rush Medical College was less fortunate. The professors in the latter school are, however, we believe, continuing their courses at one of the hospitals.

Many of the physicians in Chicago have had their libraries and surgical instruments destroyed, and donations of either of these will be acceptable.

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The American Pharmaceutical Association.—This active and highly useful association held its nineteenth annual meeting in St. Louis, Mo., on the 12th, 13th, 14th, and 15th of September last. The attendance of members was large, and a number of valuable and instructive papers and reports were presented. The minutes of the meeting, which are reported in the *American Journal of Pharmacy* for October, show that the proceedings were judiciously restricted to matters of pharmaceutical and scientific interest, and that the discussions were conducted with the utmost dignity and propriety.

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Horace Greeley on the Woman Question.—Mr. Greeley, in a letter to the editor of the *Golden Age*, says: "I have but two left of seven children, and these are both daughters. I would gladly fit them for lives of usefulness and honour, as beloved and loving wives of virtuous, upright, noble men, and mothers, if it shall please God, of good, healthy, happy children. If it be decreed that they are to be, not such women as those I have most admired and reverenced, but men with a female physique—powerful in ward caucuses and nominating conventions, vehement in Senate and on the stump, and effective before juries in the trial of actions for *crim. con.*—I pray that my career on this globe shall close before theirs is fairly begun. When and where they shall thus shine, it will not be pleasant for me to stay."

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Obituary Record.—Died, Sept. 8, 1871, at Norfolk, Mass., of apoplexy, John Edwards Holbrook, M.D., formerly Professor of Anatomy in the Medical College of South Carolina. Dr. H. was not only an excellent anatomist, but also a distinguished naturalist. His splendid work, in five quarto volumes, entitled "North American Herpetology," is justly esteemed as a most valuable contribution to Natural History.

FOREIGN INTELLIGENCE.

Deaths from Chloroform.—A death from chloroform, as in the case of other accidents, seldom comes alone. Of late, we regret to say, several instances have occurred in London and in the country. On Thursday week an inquest was held on the body of a drayman, æt. 34, at the Manchester Royal Infirmary, who, when admitted into the institution, was suffering from a fracture of the leg. Mr. J. G. Gordon, House-Surgeon, attempted to set the limb, but, after several trials, failed, as the deceased shrunk from the operation. Mr. Gordon suggested that chloroform should be administered, and the patient assented. A rag sprinkled with chloroform was accordingly placed several times in contact with the face of the deceased, and Mr. Gordon frequently essayed to adjust the limb, but the deceased could not be got sufficiently under the influence of the anæsthetic, and each attempt was unsuccessful. The pulse of the patient suddenly ceased to beat. The usual remedies for resuscitation were resorted to, without effect. Mr. S. Buckley, Physician's Assistant, made a post-mortem examination of the

body, and discovered fatty degeneration of the liver and kidneys. The brain was softened, and the heart flabby and much dilated. The witness was of opinion that death resulted from "shock to a dilated heart, whilst deceased was under the partial influence of chloroform." He considered the chloroform would not have had a fatal effect if the heart had not been so diseased. Verdict accordingly. —*Med. Times and Gaz.*, Oct. 7, 1871.

Another death occurred in the London Hospital, Sept. 24th last. The subject of it was a boy, æt. 15, to whom chloroform was given that an operation might be performed on him for strabismus. After the completion of the operation, the patient, upon recovering from the effects of the drug, made efforts to vomit. "While doing so, he gave a deep inspiration, which had the effect of forcing back the matter, and causing his death by suffocation."—*Brit. Med. Journal*, Sept. 30, 1871.

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Death from Bichloride of Methylene.—A case of this lately occurred at the Radcliffe Infirmary, Oxford. The patient, a woman, æt. 44, was about to undergo an operation for cancer of the breast. Bichloride of methylene was administered on a flannel rag. After two or three convulsive gasps, the patient expired. The quantity administered was small. Artificial respiration was practised, and other means of restoration, but without success.—*Brit. Med. Journal*, Sept. 16, 1871.

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Failure of Condurango in England.—All that we hear of the results of the trials given to the condurango bark furnished by our Government to the Middlesex and St. Bartholomew's Hospitals, through the College of Physicians, confirms the fear that any hope which might have been entertained, of a confirmation of the statement of its utility as a remedy in cancer, must be entirely dismissed. Physiologically, it appears to be practically inert, and its therapeutic effects in the treatment of cancer to be *nil*. It furnishes a slightly bitter extract of feeble characters. A detailed therapeutical report will be made by Mr. Hulke, and a careful examination of its physiological action by Dr. Brunton, but this mainly in deference rather to the official sources from which this small supply has been furnished, and to set at rest the excitement caused by the somewhat scandalous claims which have been set up in its favour.—*Brit. Med. Journal*, Sept. 9, 1871.

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Vapour of Ammonia in the Treatment of Whooping-cough.—Mr. John Grantham states (*Brit. Med. Journal*, Sept. 16, 1871) that in cases of whooping-cough in the last stage (that is, after the third week) which he has had recently, he has had one ounce of the strongest liquid ammonia put into a gallon of boiling water in an open pan, and the steam kept up by means of half a brick made red-hot throughout and put into the boiling water containing the ammonia, the pan placed in the centre of a room, into which the patients were brought as the ammoniated steam was passing off. "This method was used in the evening, just before bedtime; and it has been so efficacious," he says, "in abating the spasmodic attack, and after three or four days terminating the malady, that I cannot overestimate the great value of this mode of inhaling the ammonia as a therapeutic agent in tranquillizing the nervous system in whooping-cough."

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Treatment of Chlorosis.—M. Delioux de Savignac proposes, in the *Bulletin de Thérapeutique*, the following formula as being likely to fulfil most completely the ordinary indications of treatment in chlorosis: tartrate of iron and potassa, ten grammes; powdered aloes, two grammes; powdered castor, two grammes; powdered saffron, one gramme; to be made into a mass with Venice turpentine and divided into a hundred pills. At first, three pills are to be given daily, and the number is to be gradually increased to six or nine; care being taken to maintain a free action of the bowels without producing diarrhœa. The pills are to be taken three times daily; early in the morning and at luncheon and dinner. M. Delioux de Savignac explains that the aloes is in-

tended to obviate the constipation frequently met with in chlorotic patients: the castor oil and saffron to relieve flatulent distension of the abdomen; while the turpentine exercises a beneficial influence on the leucorrhœa. If the aloes act too energetically, it may be replaced by rhubarb; or, if constipation remain obstinate, a little jalap, scammony, or gamboge may be added. If the bowels be already free, M. Delioux omits the purgative altogether. When the turpentine produces gastric disorder, or colic with or without diarrhœa, balsam of Peru may be substituted for it. The use of the pills is contraindicated in chlorosis attended with menorrhagia.—*Brit. Med. Journal*, Sept. 30, 1871.

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Treatment of Nævus by the Galvanic Cautery.—Dr. Maas, of Breslau, has collected in the *Archiv für Klinische Chirurgie* (vol. xii.) the histories of 112 cases of nævus treated by the galvanic cautery. The results were as follows: *Capillary Nævus*—cured, 32; improved, 1; result unknown, 1. *Cavernous or venous nævus*—cured, 72; improved, 8; result unknown, 1; died, 3. *Arterial or racemose nævus*—cured, 2; improved, 1. *Nævus combined with other tumours*—cured, 6; improved, 1; result unknown, 2. He derives from the examination of the cases the conclusion that the galvanic cautery is followed by the best results in nævus, and is much safer than the injection of perchloride of iron or any other coagulating fluid. It would, however, be wrong to say positively that the remedy is indicated in all cases of nævus. As Virchow has well remarked, the surgeon must take the circumstances of each case into consideration. The battery used in the cases referred to was that of Middeldorpf.—*Brit. Med. Journ.*, Sept. 30, 1871.

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Tetanus.—Among other interesting papers lately read before the Academy of Sciences in Paris, was one by M. Demarquay, in which he showed that several cases of lock-jaw had been cured by extremely hot air baths, followed by the injection of morphia under the skin.—*Lancet*, Sept. 23, 1871.

Wasp-stings.—Dr. Drury states (*Brit. Med. Journal*, Sept. 23, 1871) that during the previous three weeks he had been called to treat no less than seven cases of illness caused by stings of wasps. He recommends the following treatment for them: "A careful examination of the wound should be made with a good pocket-lens, and any remnant of the sting removed with a pair of fine-pointed forceps. Laudanum should be applied by means of a cotton-wool swab for at least ten minutes, followed by warm water fomentations. Internally, brandy and hot water should be given at once, and twenty minims of aromatic spirit of ammonia every half hour as long as there is depression. If the mouth or throat be stung, warm flannels should be applied to the neck, and warm inhalations with ether employed. There is sure to be spasm of the rima glottidis in these cases. In no case that I have seen yet would I have given opium internally; I doubt anything but mischief from its use in any of these cases, but I am aware it has been recommended by medical writers. If local pain be not subdued by the application of the laudanum, then I think I would try the effect of hyoscyamus poultice or tincture of belladonna sprinkled over a warm damp flannel, and applied to the wound.

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Efficacy of Vaccination.—Dr. De Renzy quotes the following interesting fact:—

"The priest of the Mahomedan shrine of Bahawul Hug, at Mooltan, Mukdum Shah Mahomed, consented, at the request of the Deputy Commissioner General Van Cortlandt, C.B., to have his son vaccinated; and I performed the operation myself, hoping that the example set by this high religious authority would have a good effect in inducing other Mussulman parents to allow me to vaccinate their children. The priest, indeed, had little faith in my assertions of the efficacy of vaccination; but, as he thought it could do no harm, he yielded, from a feeling of courtesy to General Van Cortlandt, so far as to have the child operated on. In due course, and some time afterwards, the ceremony of inoculation,

which had been practised for many ages in the Mukdum's family, came to be performed; and then, to his surprise, he discovered that the boy would not take smallpox. The most skilful inoculators tried and failed to produce the disease. The experiment satisfied the Mukdum of the truth of what I had told him — that vaccination, properly performed, is an almost sure preventive of smallpox. The boy is now himself the priest of the shrine of Bahawul Hug, his father having died two years ago. Unlike his father, who was deeply pitted with smallpox, he does not bear the smallest trace of that terrible disease."—*Brit. Med. Journal*, Sept. 30, 1871.

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The Use of Secondary Lymph.—Our Manchester correspondent writes that the extent to which revaccination has been practised in Manchester during the last few months, has afforded rare opportunities for deciding some questions which were before held by some to be still *sub judice:* for example, the custom which has prevailed among the millowners of having all their workpeople vaccinated, has settled the question of the value of secondary lymph, as compared with virgin lymph. Out of many similar experiences, the following may be quoted by way of illustration. A fortnight ago, a surgeon vaccinated 300 operatives; in 150 of these cases he employed virgin lymph; in the remaining 150, secondary lymph was used. The first series gave the following results: 19 cases were unsuccessful; in 16 cases, small papules and spurious vesicles resulted, while the remaining 115 all showed well-marked primary vesicles. The second series gave very different results; for out of them, 50 were entirely unsuccessful, 86 terminated in papules and small spurious vesicles, and only 14 yielded true primary vesicles.—*Brit. Med. Journal*, Aug. 19, 1871.

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Gelatine as a Vehicle for Powerful Medicines.—Dr. T. Huseman gives an account (*Centralblatt f. Med. Wiss.*, No. 157) of the method of Prof. A. Almen, of Upsala, for the administration of medicines by means of the gelatinæ medicatæ in lamellis. This method which has been extensively used in Sweden, renders the administration of powerful medicines easy and exact. Glue (6 grammes) is dissolved in warm water (230–260 cent.) and then the medicine added. The solution is poured upon a plate of glass to solidify and dry. The stiffened mass, of the thickness of paper, is divided into squares, each of which contains a certain dose. A slight addition of glycerine serves to make the otherwise brittle gelatinæ tough, and flexible as paper. Too much glycerine makes the gelatinæ soft and too readily moist. With insoluble drugs, it is necessary that the medicine be added to the solution of glue in a thick emulsion; gum-acacia is to be preferred to gum-tragacanth. The gelatinæ must not be placed dry upon the tongue, but moistened and swallowed with a gulp of water. The chief drugs thus used by Prof. Almen are: Gelatinæ morphii acetici, tartarized antimony, acetate of lead, sulphate of copper, extract. opii, opii levantici, extract. belladonnæ, extract. colocynth comp., hydrarg. chlorat. mitis, pulv. rad. ipecac, infusion ipecac., pulv. fol. digitalis, infusion digitalis, camphoræ. The gelatinæ atropini and physostigmatis, for local application to the eye, have proved useful, but the gelatinæ sinapis and cantharidum for external application to the skin have not yet been thoroughly tried.—*Medical Press and Circular*, Aug. 23, 1871.

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Anhydrous Glycerine.—M. Eberhard has called attention to the power possessed by absolutely anhydrous glycerine of withdrawing water by an exosmotic process from tissues to which it is applied. Marion Sims some time ago demonstrated that a ball of lint dipped in glycerine and applied to a freely suppurating surface, arrests the secretion. Turst has also applied the glycerine plug in a large number of cases of fluor albus, and M. Eberhard states that he has been very successful in applying the same means in similar cases.—*The Druggists' Circular*, Oct. 1871.

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Cholera.—At the present time epidemic cholera is prevalent in the pachalik of

Bagdad, in the central and northwestern provinces of Persia; in the trans-Caucasian provinces of Russia; in several of the Russian ports of the Black Sea and Sea of Azov; throughout Russia in Europe, and in the provinces of Germany on the Baltic and North Sea. The disease is extending from the pachalik of Bagdad into the Hedjaz, from the Black Sea to the Bosphorus, and from the seaboard provinces of Germany to the central provinces of the empire. In presence of a widely-spread extending epidemic of cholera, which has effected a lodgement in the westernmost parts of Europe, and is increasing there, the danger of the epidemic invading Great Britain can hardly be held to be remote, or the precautionary measures premature which are now being so strongly urged upon local authorities. —*Lancet*, Sept. 30, 1871.

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Purifying of Hospital Wards.—M. Rabot states (*L'Union Médicale*, Aug. 20, 1871) that he has succeeded in purifying hospital wards, without disturbing the patients, by the following means: An oxygen-generating apparatus is placed outside the building, and, by means of a long India-rubber tube, a volume of oxygen is introduced, measuring about the thousandth part of the cubic feet of the room, after the ward had, as usual, been well ventilated. To feed the patients' curiosity, a few fumigations with cascarilla were made. In both extremities of the ward large basins containing one pound of peroxide of manganese and ten pounds of the solution of hyperchloride of lime were placed and changed every day. The method has been conscientiously applied by M. Rabot in a hospital at Versailles, with the best results.

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Homœopathy.—The *Lancet* (Sept. 30, 1871) in commenting on the appointment of a professing homœopath as a union medical officer, makes the following just remarks: "No one ought to be placed in charge of the sick poor who professes to depend entirely on some particular specialty or peculiarity of treatment, and who is thus shut out, *ipso facto*, from the general principles of therapeutics, and may for that reason be obliged to offend the prejudices of the sick, who are most concerned in the matter. Private persons may go to what doctors they please; but it is the duty of the State to provide that its medical officers should be, in the widest sense of the term, general practitioners, and not curtailed in their usefulness by the chains of some narrow hypothesis or some peculiar crotchet.

—

Sugar of Milk in a Vegetable Juice.—M. M. G. Bouchardat has discovered in the juice of the fruit of the sapota tree, (*Achras Sapota*) a crystalline saccharine substance, perfectly identical with the sugar obtained from the lacteal secretion of the mammifera.—*La Revue Scientifique*, Aug. 26, 1871.

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Vienna.—Prof. Kœrner of Gratz, one of the most eminent of the German professors, and well known by excellent works on tuberculosis, movements of the heart, fever, &c., has been appointed to the chair of Professor Oppolzer.—*La Santé Publique*, Sept. 21, 1871.

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Obituary Record.—Died, at London, on the 24th of September, in the 66th year of his age, Samuel Solly, F.R.S., formerly Senior Surgeon and Lecturer on Surgery to St. Thomas's Hospital, and President of the Royal Medical and Chirurgical Society. Mr. Solly's principal contributions to medical literature were a work "On the Human Brain," which earned for him an election as Fellow of the Royal Society; a large volume of "Surgical Experiences," and "An Analysis of Müller on the Glands."

—— In Paris, 18th Sept. last, M. Blache, formerly President of the Academy of Medicine. Dr. B. enjoyed great reputation in the treatment of the diseases of children, and was highly esteemed and honoured by his brethren.

—— August 30th, aged 47, Hyde Salter, M.D., Physician to Charing-Cross Hospital. Dr. S. was an eminent physician in London, and well known in this country as the author of a valuable work on Asthma, reprinted in the Library Department of the *News* for 1863.

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GUERSANT ON SURGICAL DISEASES OF INFANTS, ETC., 16 PAGES.

CLINICS.

CLINICAL LECTURE.

Abstract of a Clinical Lecture on a Case of severe Injury to the Lower End of the Femur. By PRESCOTT HEWETT, Esq., F.R.S., Surgeon to St. George's Hospital.

GENTLEMEN: The subject which I bring before your notice to-day is one of great interest, and one which may be to you, by and by, in practice of the utmost importance, and which might, in some measure, affect your reputation: I allude to the case of the girl in the Wellington Ward, in the third or fourth bed from the right. She was admitted into the hospital on the 21st September last, and, as it is now the 17th of October, she has been a month in the hospital. She was walking down a flight of stairs at the International Exhibition, and, while doing so, she caught her foot on the edge of a step and fell, sustaining, it was supposed, a fracture of the end of the femur. She wore high-heeled boots. I do not know how it has happened, but there have been a great many accidents in the International Exhibition. I suppose they must have arisen partly from the height of the stairs, and partly from the height of the ladies' heels. Ladies are anxious to look tall, thinking that their appearance is improved, and therefore they wear high-heeled boots. Such accidents are not always, however, due to the high heels, for a lady whom I knew fell by tripping on the stairs at the Exhibition, and came down on the cheek-bone, breaking it, and having ecchymosis on the right side of the face for months afterwards. But the first thing to which I would call your attention in this case is the high heels of the boots. Ladies will, for the most part, wear them; but they could not do a worse thing, for their feet are placed in a difficult and most unnatural position. They are very tenacious about this fashion, but you must be as tenacious against it: the number of accidents in consequence is very great. To

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show you how very tenacious ladies are on this point, last year I was sent for to see a young lady in one of our London hotels. She wished to consult me about her foot. On seeing it, I thought its state depended upon her boots, and I asked to see them. The boots were brought in by the lady's maid, but the only thing I could observe about them was an immensely high heel. I said: "It is the high heel of your boots that causes the mischief, and unless you diminish this I can do nothing for you." She became quite angry, and said she could not alter them. "I cannot do it, and I will not." Suddenly again she toned down, and said: "Pray, sir, what would people say if they saw me walking about the park without high heels?" I said: "It is simply heels *versus* brains. If you have brains, you will cut off the heels; if you have no brains, you will continue to wear them." She fortunately had brains, cut off the heels, and her foot got quite well.

To return to our patient. On admission to the hospital, this girl was, as I said, supposed to have a fracture of the lower end of the femur, close to the joint, and the injury was all but compound. A long splint was applied, but it was very difficult to keep the fragments in their proper place; and, as the surrounding parts became very swollen and painful, the patient was put on an Earle's bedstead on the 26th, and then matters went on until I returned from my holiday, when I took charge of my patients on the 2d of October, and saw this girl, being told there was great difficulty in keeping the fragments in their proper position. On examining the leg, after taking off the short splints, I found that there was a large projection on the outside of the thigh-bone, due to the upper piece of the bone pressing against the skin. And now a closer examination of the parts led me to think that, after all, the case was perhaps one of separation of the epiphysis, and not a fracture. The injury is close to the knee-joint. The bone projecting is certainly not more than an inch above the condyle; the fragment, instead of being sharp, is obtuse; in addition to which we have the age of the girl, 17, and the nature of the accident. This case is, then, I think, one of separation of the epiphysis of the femur.

Severe injuries of the lower end of the femur may be of two kinds—a fracture close to the knee-joint, and a separation of the epiphysis; the former is by far the more common form of the injury—the latter being, indeed, rarely met with in adults. It is but a few years ago that we were first quite clear as to what happens in the separation of the epiphyses, and all the cases published then were cases of children. I presume that you know we have a line of cartilage at the lower epiphysis of the femur. So long as this exists, so long may a separation take place. The question then arises, At what time of life does this piece of cartilage disappear and the condyles become joined to the shaft? The age varies in different individuals. The cartilage sometimes exists up to the age of 25 years. You will find in most of the authors no allusion made to the possibility of this accident from 18 to 25: it is only mentioned in a very casual manner that this does not take place after 14 or 16. However, I have had several cases at a later age than that. [Here Mr. Hewett showed a specimen in which there was a separation of the epiphysis at the age of 18.] You see the condyle completely torn off; it happened when I was assistant-surgeon. You will find a very accurate history of this case in the Catalogue of our Museum, vol. i. p. 137. There was also in this case a separation of the epiphysis of the tibia and lower end of the fibula. The limb, from the knee downwards, was icy cold, and there was great swelling about the ankle. Mr. Cæsar Hawkins, under whose care the patient was, amputated the thigh. On dissecting the knee-joint, all the deformity was found to depend upon a separation of the epiphysis, and the coldness of the joint upon an injury to the popliteal artery. The case in the hospital now reminds me very strongly of Mr. Hawkins's case. Now this case is one which might in a country village lead you into great trouble. You may depend upon it that, if such a case as this unluckily fell into your hands when you were begin-

ning practice, it would be said that you did not know your business or you could make it all right. In a separation of the epiphysis what happens is this: the cartilage is torn from the bone in some parts, and in others the bone itself gives way, so that there is a very irregular jagged surface. To readapt such surface is a very difficult matter. You may bring one part into the proper place but not another, and such is the case with this girl. If a dissection were made, you would probably find such to be the condition of the parts.

I have shown you a specimen of separation of the epiphysis from our museum at 18 years of age. There is another such at 17, and two at 16, and all these histories are fully detailed in the Catalogue; and there might be separation of the epiphysis at a later age even than 18. Always bear in mind that such may possibly happen, but very rarely, it is true, till the age of 25.

[Mr. Hewitt then dwelt on fracture, properly so called, of the lower end of the femur, narrating some interesting cases, and exhibiting a number of specimens involving the condyles from the museum. He then proceeded.]

Having made out what is the nature of the accident in this girl, I must make some mention of the plan of treatment. In the present day, we for the most part use the long splint in cases of fracture about the lower end of the femur. When this girl came in, the long splint was applied; but Mr. Rouse, after two or three days' trial with this splint, resorted to the inclined plane. The first was Earle's bedstead; and then, finding that this did not answer, I ordered a common inclined plane, since which the parts have been kept in much better apposition, and she now finds herself much more comfortable. In addition to the inclined plane on which the limb rests, we have short splints on the outer, inner, and upper parts. I have been very careful to tell the girl that she will have some deformity about the thigh, although it will not interfere with her walking. And when you have a case of this kind to deal with, gentlemen, and you see that there must be some deformity, you will find it wisest to tell your patient and friends that such must be the case.—*Brit. Med. Journ.*, Nov. 4, 1871.

HOSPITAL NOTES AND GLEANINGS.

Removal of a Fungoid Tumour in the Upper Arm.—Sir Wm. Fergusson on Oct. 14, removed a large fungous mass, of about the size of a cocoa-nut, situated near the shoulder of a sickly-looking man, aged 34. The knife was swept around the tumour, and the bulk of it removed; but it required very careful dissection for ten or fifteen minutes to separate its connection with the biceps and other structures about the joint. After a few arteries of no great magnitude had been tied, and others pinched, the wound was closed, and the patient removed to bed. Sir William Fergusson then made the following remarks:—

This is a case, gentlemen, peculiar in a variety of aspects. This patient was born with certain tumours upon him; and at that time he was seen by some of the first men in the profession in England, who all doubted the propriety of interference, because they were uncertain as to the character of the tumours. There was one particularly near the left eye, and another under the clavicle, and both of such magnitude that the patient was looked upon as one not likely to live long. But the child lived to boyhood, and the boy grew up to manhood; and twelve years ago he came under my notice. I decided as to the character of both the tumours; and both were removed with facility, and without subsequent evil. He had then a number of molluscous tumours about him, but these were not meddled with. One of them, on his arm, however, increased so much in size that it was removed five months ago. It was of the size of a walnut. The disease returned in the cicatrix, and has in that brief time—since May last—grown to the size you saw. I had the privilege of seeing him last week, as I took a special interest in the case, and considered that the disease was likely to prove serious. It would have been a pity to have subjected him to amputation of the whole arm, because it was perfectly healthy save this fungoid tumour. It struck me that the tumour

might be removed; and I gave that advice, and was prepared to operate. But I was also prepared to amputate if necessary—if the tumour involved the other tissues in the neighbourhood. I had doubt about it, and thought that it certainly did involve the biceps. I could scarcely think that it involved the brachial artery and nerves: if it did, amputation was the only resource. Now, on proceeding with the dissection, it did not give much promise at first; but the biceps muscle I recognized early in the operation, and saw that the tumour was attached to the outer and back part of it, and that I could save a large proportion of the muscle. I cut through its aponeurósis; and then a careful dissection enabled me to take out the larger portion of the tumour. It then became apparent that the deeper part of the tumour was to the outer side of the brachial artery and nerves, and so I proceeded with much more freedom. Looking at the health of the patient, I may say that the prospects are not specially good; but yet there is the arm now without an unsound tissue upon it, and without any structure of importance taken away. Even supposing this to be a malignant tumour, amputation itself would have afforded, perhaps, no better prospect than the partial removal which you have now seen.—*British Med. Journ.*, Oct. 28, 1871.

—

A Record of Cases of Cancer of the Breast.—The following record of ten cases of malignant disease of the female mamma have been operated upon eleven times at the Bradford Infirmary, England, within about twelve months; two died of the operation; three have died since, one of return of the disease locally, and two from constitutional return (of these one in the liver and one in the lung); in two more the disease has recurred locally; and in three there has been no recurrence of the disease up to the present time. In the cases of the last three patients, the longest interval between the date of operation and the present time is nine months; in another the interval is five months; and in the last the interval is three months. The disease has recurred in *every one* of the cases in which the axillary glands were involved at the time of the operation.

Dr. Rabagliati observes that it is not easy to understand how the above results are to be reconciled with the local theory of origin of the disease, which Mr. Campbell De Morgan advocates. Although some fair objections are urged by that writer against the other, or constitutional, theory of origin, chiefly as to the difficulty of understanding how the blood of patients suffering from cancer can eliminate locally the *materies morbi* it contains, he thinks it must be admitted that the weight of evidence is against that view. It is in particular difficult, if not impossible, he says, to reconcile with it the recurrence of the disease, either (1) locally; or, still more so (2), constitutionally or internally, as occurred in case 4 of this series, in which it is specially to be observed there was no glandular involvement at the time of operation, and no evidence, therefore, of affection of the constitution at that time. Yet the *materies morbi* must have been in the blood; or, if this be objected to, at any rate the blood must have been infected, and the constitution must have had quite ineradicable tendencies to the disease. When to these arguments is added the consideration that cancer can frequently be shown to be a disease transmitted hereditarily, the difficulties of maintaining the local theory of its origin are, Dr. Rabagliati adds, immensely, if not quite insuperably, increased.—*Lancet*, Sept. 12, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Death from Chloroform.—It is stated (*The Clinic*, Oct. 28, 1871) that in a case of old dislocation of the elbow, chloroform was given to secure relaxation. After it was administered for five minutes, the desired effect being obtained, it was withdrawn. Suddenly it was noticed that the pulse began to flag. The extremities became cold, respiration was gasping, and soon ceased altogether. Dr. Muscroft [of Cincinnati], the operating surgeon, re-

sorted to artificial respiration and acupuncture of the heart without avail.

—

Smallpox in Philadelphia.—The smallpox epidemic which prevailed so extensively last year in London, and the previous year in Paris, has extended to this country, and is prevailing to a greater or less extent in New York and Philadelphia.

The following table shows the number of deaths each week from the disease in Philadelphia since Sept. 2, 1871:—

Week ending	September	2	0
"	"	9	1
"	"	16	6
"	"	23	4
"	"	30	7
"	October	7	23
"	"	14	54
"	"	21	74
"	"	28	85
"	November	4	95
"	"	11	101
"	"	18	133
"	"	25	153

—

United States Navy.—Dr. W. Maxwell Wood, who for the past two years, as chief of the Bureau of Medicine and Surgery, U.S.N., has conducted that office most acceptably, and with great ability, has been relieved on account of length of service, and been appointed Inspector of Fleets and Hospitals.

Dr. Jonathan M. Foltz has been appointed chief of the Bureau of Medicine and Surgery, U.S.N.

The high character of this officer, and his well-known ability, afford sufficient guarantee that he will maintain the efficiency of the department, and uphold the rights of naval surgeons to a proper recognition of the valuable services which they are required to perform.

—

Medical Relief Committee of Chicago.—It appears that the medical profession of Chicago have been severe sufferers by the late conflagration in that city, many of them losing their entire libraries and surgical instruments. They have just claims upon their professional brethren for contributions for the repair of their losses, and we take pleasure in giving place to the following announcement:—

At a meeting of physicians held on the 17th October, of which Dr. N. S. Davis was made chairman, the announcement having been made that communications had been received from prominent physicians of other cities, to the effect that contributions, for the relief of the suffering members of the profession here, are now awaiting the order of responsible parties to receive and disburse them, the following gentlemen were appointed a permanent relief committee: Drs. N. S. Davis, DeLaskie Miller, Ernst Schmidt, T. D. Fitch, and Walter Hay; and the following resolutions were adopted:—

Resolved, That the committee just chosen is hereby authorized to receive all donations for the relief of the respectable physicians who are sufferers by the late fire, distribute the same at their discretion, and render a strict account, with vouchers, to any future meeting, which may be called by the chairman, to consider the same.

Resolved, That this meeting tender the cordial and heartfelt thanks of the profession of this city to their brethren in other and distant cities, for the prompt and liberal offers of assistance to the many among us who have lost, by the late terrible fire, not only their homes, clothes, books, and instruments, but their practice, and pledge a just use of whatever is given.

Contributions may be forwarded at once by express, or draft on New York, to Walter Hay, M.D., Secretary Medical Relief Committee, No. 384 Michigan Avenue.

Donations from publishing houses, instrument makers, and physicians, of books, instruments, or apparatus, will be gratefully received, as many of our professional brethren have saved only their lives.

—

Rush Medical College, Chicago.—The resident Alumni of Rush Medical College, at a meeting held at the house of E. Ingals, M.D., on October 17, 1871, appointed the following Executive Committee, to present an appeal to the Alumni and friends of the College, for aid to rebuild and refurnish the College Building, viz.: Drs. T. D. Fitch, Chairman; H. A. Johnson, V. L. Hurlbut, C. T. Parkes, Ben. C. Miller, and F. A

Emmons. This committee has issued the following appeal, which we take pleasure in laying before the medical profession, in the hope of aiding the laudable object in view:—

"This College is among the oldest institutions of learning in the Northwest, having been in operation since 1843, at which time the region now tributary to Chicago was but sparsely populated, and had little wealth. During this time it has supplied a pressing need of this new country. It has educated a large number of young men, who are scattered through our whole country, worthily filling places of great usefulness and responsibility; and for this both themselves and the public are indebted, in a great measure, to the school in which they received their instruction. A large proportion of its students have been possessed of little save youth, hope, intelligence, and determination. Many of these, having been generously aided by the College, have taken rank among the most substantial members of the profession. The Faculty at all times, since its organization, has been moved by an earnest desire to promote the best interests of the profession and the College. For this its members have laboured faithfully and earnestly; they have met the pecuniary burden of the school from its first foundation, and four years since they erected from their own resources, at an expense of $70,000, the most ample and best appointed college building on this continent, and filled it with every necessary appliance for successful teaching, and the influence and usefulness of the school have steadily increased from year to year. But in a day the college building, with all its contents, was swept away, along with a large part of the city, in which it stood a peer among many other noble institutions of learning. The pecuniary loss of the Faculty, in the destruction of the College, is light when weighed against others they have sustained. A number have lost everything, and all have suffered much. The college must be rebuilt. Its past history, its future promise for good, demand no less. Under the circumstances, it is unreasonable to expect the Faculty to do this unaided. The College is now in a condition to justify an appeal to its Alumni, and to society, for some return for the favours it has conferred upon both. There is, perhaps, no field of benevolence that offers a richer return than to provide adequate and easy opportunities for instruction to those who desire to become learned in the best means for assuaging pain and healing the sick.

"All donations may be remitted to Chas. T. Parkes, M.D., 462 Elston Av., Chicago, who has been elected treasurer for the fund. They will be thankfully acknowledged, and devoted to the rebuilding of the college."

The trustees of the College make the following offer, which, we regret to say, we cannot commend as tending either to maintain the dignity or uphold the honour of the profession:—

"For every donation of five hundred dollars the trustees will establish a perpetual free scholarship, which shall bear the name of the donor, and which shall be conspicuously emblazoned on the wall of the lecture-room. A certificate of this scholarship, engrossed on parchment, will be issued to the donor; which certificate shall secure to the bearer free tuition, and, when found qualified, free graduation. This certificate shall be perpetual in its operation; and thus the donor will have endowed for one student each year a Free Medical College."

—

Mr. Erichsen's Claim.—Some of our contemporaries have been led to reprint a curious statement that the United States is virtually the debtor to Mr. Erichsen, the distinguished London surgeon, for about £3000, the amount of profit that he would have derived from the sale of 5370 copies of his "Science and Art of Surgery," supposed to have been used by the medical staff of the army during the war, had our government purchased the English edition instead of the American reprint. A claim for this, it seems, was presented by Mr. Erichsen, but not replied to.

It is true that after the war there was published an abstract of supplies issued by the Surgical Bureau, in which Mr. Erichsen's book figures to the extent of

5370 copies; but a careless reading of this statement was calculated to lead to a very erroneous inference, as it was made up from the aggregate of seven dépôts, which frequently transferred stores from one to another. It made *no pretence of being practically correct.* In the same table "Bumstead on Venereal" was set down for 7317 copies, when only 578 copies were actually purchased by the government. Besides this, the records of all the systematic works on surgery were kept together, and printed under the name of the book which *happened to come first* on the list, and this chanced to be Erichsen's; while there were on the "supply table" a number of others, such as Gross's, Druitt's, Smith's, and Malgaigne's, all of which were used; the aggregate of the whole being summed up under the name of Erichsen.

Large as is the profit claimed by Mr. Erichsen, amounting in currency, at the rates of exchange current during the war, to about $6 per copy, the government perhaps could afford to pay him for what it actually used, as the English edition of the book would have cost at that time some $10 to $15 per copy to import, without duties; while the American edition, in the same style of binding, was supplied at about $4 50.

We happen to know, further, that every American edition of Erichsen's Surgery has been issued under an arrangement with the London publisher.

—

The Physician's Visiting List for 1872.—This work, which has now been before the profession for twenty years, is so well known, and its convenience appreciated, that it is only necessary to announce its publication by Messrs. Lindsay & Blakiston.

FOREIGN INTELLIGENCE.

Chloral in Cholera.—During the epidemic which has recently prevailed at Riga, Dr. von Reichard has had recourse to chloral, administering it according to the following indications: "1. To relieve the cramps at the commencement. 2. To assuage the præcordial suffering which is so distressing during the latter stages. 3. To arrest vomiting. 4. To procure the sleep so urgently demanded by the patients. Not only were these indications fulfilled, but the success obtained from the medicine surpassed all expectation. In one case in which the ordinary treatment had been pursued, and the patient seemed as if he had only a few hours to live, a drachm of chloral was given him in four times the quantity of water, so that a strong sense of burning was felt while swallowing it. In two minutes sleep had commenced, and, troubled at first, it became calm and lasted three hours. Respiration became easier, the warmth and turgescence of the surface reappeared, the cholera *facies* disappeared, and the pulse diminished from 130 to 90. The vomiting and stools ceased, and, in fact, a true resurrection was effected, the patient rapidly recovering. M. Blumenthal, also of Riga, has employed it successfully in two bad cases, giving the chloral in doses of a drachm, which were repeated two or three times within the hour.—*Medical Times and Gazette,* Oct. 28, 1871, from *L' Union Méd.*, Oct. 17.

—

Chloral in Toothache.—Dr. David Page states (*Brit. Med. Journ.*, Sept. 2, 1871) that he has been for some time in the habit of using *chloral hydrate,* not only as an internal sedative in cases of severe dental neuralgia and of caries where it was at the time inadvisable to permit extraction, but more frequently as a direct local application to the carious tooth. A few grains of the solid hydrate introduced into the cavity of the tooth upon the point of a quill, speedily dissolve there; and in the course of a few minutes, during which a not unpleasant warm sensation is experienced, the pain is either deadened, or more often effectually allayed. A second or third application may be resorted to if necessary. The hours of agony that various circumstances may otherwise entail, are in this way avoided; and in the last instance under my notice, a young lady in a delicate state of health, suffering intensely from a carious tooth, received immediate relief from this application.

—

Condurango.—We have received from Mr. Davidson, the house-surgeon of the

Middlesex Hospital, a short paper on the treatment of cancer by the internal administration of the decoction of condurango. The results plainly show that condurango is as futile as any of the cancer cures which have preceded it. It was used in four cases—(1) in an ulcerated epithelioma of the roof of the mouth; (2) in primary cancer of the penis, and secondary injection of the lymphatic glands in both groins; (3) in an ulcerated epithelioma of the scrotum; (4) in an ulcerated scirrhus of the female breast. In all of these cases the condurango had positively *no effect* upon the progress of the disease.—*Lancet*, Oct. 28, 1871.

Mr. HULKE adds (*Med. Times and Gaz.*, Nov. 4, 1871), "as a reputed remedy for cancer, condurango is, in my opinion, perfectly inert and useless."

—

Strychnia in Albuminuria.—BRIGNOLI, in *Lo Sperimentale*, besides recommending nux vomica in various neuroses, gastralgia, dyspepsia, cardiac palpitations, periodic cough, etc., states that he has observed it to have a marked effect in retarding the progress of albuminuria, especially the scarlatinal form with anasarca. He cites twelve cases of complete recovery.—*British Med. Journ.*, Oct. 28, 1871.

—

Vomiting of Pregnancy.—Dr. HUBERT, in a memoir read before the Medical Society of Lyons (*Lyon Médical*, 15th Oct. 1871, p. 467), produces evidence to show that in some cases the symptom depends upon displacement and movements of the uterus, and that it may be arrested by the immobilization of the uterus by suitable bandages and the use of Hodge's or Zwanke's pessary.—*British Med. Journ.*, Oct. 28, 1871.

—

Extirpation of the Entire Parotid.—In the *Deutsche Klinik*, 1871, No. 37, is given a detailed translation from the *Sperimentale* of the total extirpation of the parotid, by Prof. MARCACCI, of Sienna, the divided carotid at its temporal end, and several other vessels, being tied during the operation. The ligature around the carotid only came away three months after the operation, but the wound had cicatrized, with the exception of the aperture for this, long before.—*Med. Times and Gaz.*, Nov. 11, 1871.

—

Pessary for Offensive Uterine Discharges.—We understand that Dr. JOHN DAY, of Geelong, has recently been using with great advantage a new kind of pessary as a means of removing the offensive odour given off in certain uterine diseases, as cancer, etc. These pessaries are made by gently melting cocoa butter, and then adding to it ozonic ether in the proportion of a drachm of the latter to an ounce of the former. The addition of about one-eighth part of white wax will give greater solidity to the mass, and in hot weather seems an improvement. Each pessary should weigh about a drachm and a half. The mass thus prepared retains its active agent, the peroxide of hydrogen, for a month or longer, as may be readily proved by scraping a few fine shavings from a pessary on a drop of blood or pus lying on a piece of white paper, then folding the paper, and holding it between the forefinger and thumb for a minute or two, so as to dissolve the cocoa butter, and lastly adding a drop of tincture of guaiacum (oxidized if pus is used), when a blue reaction will at once take place.—*Med. Times and Gaz.*, Nov. 4, 1871.

—

Connection of Various Diseases—Variola.—The Vienna correspondent of the *Lancet* states that Prof. HEBRA recently made two most interesting and practical remarks on the connection of various diseases. Firstly, he stated that about 90 per cent. of the parents of pruriginous children die of phthisis; and, secondly, that it is very common for women who have long suffered from eczema of the head to become the subjects of cancer later in life.

A considerable number of cases of smallpox are now under treatment, two of which seem likely to end fatally. The Professor believes in no treatment beyond good food and air, and considers medicine even injurious, as irritating the pustules developed on the mucous membrane of the mouth. This is in marked contrast to the views of Dr. Monti, of the Chil-

dren's Hospital, who has recently been treating very successfully all his smallpox cases with small internal doses of carbolic acid.

I may add that Professor Hebra stoutly denies any essential difference between the contagion of variola and varicella, having seen formidable outbreaks of the graver malady produced by the introduction of a solitary example of the lighter and so-called distinct disease.—*Lancet*, Nov. 4, 1871.

—

Preservation of Vaccine Lymph.—We would call especial attention to the remarkable success which has attended Müller's employment of glycerine for the prolonged preservation of vaccine lymph. During an epidemic visitation of variola, much of the inconvenience arising from the short supply of reliable lymph might be obviated by the adoption of Müller's plan.

In a recent communication upon the subject (*Berlin K. Woch.*, September 25), Dr. Müller points out that the purity of the glycerine employed is of great importance; and that those practitioners who have complained that the preservative power is only of short duration, have probably employed an impure article. In his hands, lymph, after being kept two years, has produced normal pocks; and in this way he has been able to store up, in the Berlin Vaccine Establishment, of which he is director, supplies of reliable lymph sufficient for vaccinating thousands of subjects. The demand made for the German soldiers and the French prisoners during the late war could never have been supplied by the means ordinarily in use. Besides this valuable preservative power, Dr. Müller considers that glycerine facilitates the operation of vaccination, dilution of the lymph by its aid producing a far more efficacious, and much more intimate and easily employed, mixture than when water is employed for this purpose. Nay, according to his own experience and that of many official vaccinators, glycerine lymph acts more certainly and more completely than when unmixed fresh lymph is employed. This, he supposes, may arise from the coagulability of the blood being diminished by contact with the glycerine, and the lymph thus rendered more easily absorbable.

In mixing glycerine with lymph, an equal portion of distilled water has to be added; but when the lymph has to be preserved for a long period, it may be mixed with the undiluted glycerine, as this will probably preserve it still longer from decomposition, and the water may be then added when the lymph is employed. Dr. Müller, however, in his trials, has not perceived any difference in the lymph treated in these two different ways.—*Medical Times and Gazette*, Oct. 21, 1871.

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Eucalyptus Globulus.—This tree is being largely cultivated in the south of France, Spain, Algiers, and Corsica. It is a native of Tasmania, where it was of old known to the natives and settlers as a remedy for fever. It prefers a marshy soil, in which it grows to a gigantic height with great rapidity. It dries the soil by the evaporation from its leaves, and shelters it from the sun, thus preventing the generation of marsh miasm. Its wood is as hard as teak. Every part of it is impregnated with a balsamic, oil-of-camphor-like odor; and besides a notable quantity of astringent matter, it contains a peculiar extractive, which is supposed to contain an alkaloid allied to quinia. At any rate, its efficacy in intermittent and marsh fevers has gained for it in Spain the name of the "fever tree." It is a powerful tonic and diffusible stimulant, does wonders in chronic catarrh and dyspepsia, is an excellent antiseptic application to wounds, and tans the skins of dead animals, giving the fragrance of Russia leather. We can vouch from personal observation for the flourishing condition of the plantations at Hyères and Nice, where trees from seeds sown in 1859 are said to be now sixty metres high.—*Med. Times and Gaz.* Nov. 11, 1871.

—

English Medical Students.—It is stated (*Med. Times and Gaz.*, Nov. 4, 1871) that the total number of registered students now pursuing their professional studies in London is 1491, in the provincial schools 368, making a grand total of 1859.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Hyperæsthesia. By C. HANDFIELD JONES, M.B. Cantab., F.R.S., Physician to St. Mary's Hospital.

Besides the classical disorders of the nervous system, which well-instructed students like you are supposed to know all about—such maladies, for instance, as epilepsy and tetanus—there are a great many forms and varieties of morbid action which are less recognized and described, and scarcely find a place in a regular nomenclature, with which yet it is very desirable for you to be acquainted. Many of these belong to that debatable ground where it is difficult to decide whether we have to do with diseases or with symptoms. I shall now proceed to notice sundry instances of one very common kind of morbid action, as it manifests itself in different localities; and conclude with some remarks on its nature, relations, and treatment.

1. In the *cutaneous surface* we very often meet with a condition which betrays itself by no objective change yet discovered, but solely by an abnormal sensitiveness. The tactile faculty of the skin is not really increased; it is not a more efficient organ of touch than it was before, but quite the reverse, as its nerves are incapable of tolerating the necessary contact with bodies presented to them. Such a condition is conveniently termed hyperæsthesia; and this name I shall continue to use in what I have further to say about it. This state of hyperæsthesia is met with very frequently in sufferers of the quasi-hysterical class, both male and female. One poor fellow assured me that his skin had been so sensitive that he could not bear the least touch anywhere; the pressure of a stethoscope in auscultation was intolerable; and the touch of a crinoline-hoop against his leg in a railway carriage caused him terrible pain. These complaints were made quite gravely; and though we can hardly avoid smiling at

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them, yet we must admit that to the sufferer himself such a state of things was no joke. Think what you would endure yourselves, if all ordinary contact were a cause of continual pain. The reality of such suffering is materially confirmed by the fact that, in some cases of structural disease of the cord, certain parts of the cutaneous surface manifest intense reflex excitability, though ordinary sensibility is much impaired. In a most workmanlike report in the *Transactions of the Clinical Society*, vol. i. p. 102, on a case of locomotor ataxy, it is mentioned that an area of skin on the outer side of the right leg, about two inches and a half square, was, and had been for about two years, in a condition of extreme sensitivity to impressions capable of exciting reflex movements—such that the patient had frequently been thrown into convulsions, and had dropped down in the street, from the mere brushing of a woman's dress against this part. Even when he touched this spot himself, either with his hand or his trousers, whilst dressing, slighter convulsive movements often took place. At these times he felt an odd kind of sensation in the part, which then diffused itself rapidly throughout the body. In such hyperæsthesia as this the sensorium is but little concerned; but there is evidently no improbability that the cerebrum might be the seat of such disorder, as well as the cord. In fact, this is actually the case in many instances of arachnitis. If you object, that I am now speaking of coarse structural lesions, this will not apply to the case of rickets, where the nervous centres are often exempt from evident lesion, and yet the general tenderness is such that the child cries if he be but touched.

The hyperæsthesia which affects the region of the spine, or, more exactly, the line of the spinous processes, needs to be somewhat specially noticed, because it has been much dwelt on, and is often accepted as a sign (with others) of meningitis or myelitis. Brown-Séquard speaks decidedly on this point; he says that "it is almost always found that pressure upon the spinous process of the vertebræ (sometimes even a slight one), when made at the upper limit of the inflammation, causes an acute pain." (*Lancet*, July 14th, 1860.) Dr. Radcliffe, on the other hand, is inclined to the view that this pain is mostly absent, at any rate, in uncomplicated myelitis. My own experience leads me to look for it as a nearly constant symptom, but not in that degree of acuteness which characterizes the neurotic disorder. This, at any rate, is certain: that pain in the back *per se* is no evidence whatever of inflammation being present in any of the component structures, any more than headache is of the cranium and its contents being so affected; and, indeed, the two dysæsthesiæ are in many respect homologous. Spinal hyperæsthesia extends sometimes over the skin on one side, and not at all on the other; sometimes light pressure is painful, and firm relieves; sometimes the latter is the worse. In some cases, I believe, the bones are involved in the neuralgia, without being at all inflamed.

2. The *lingual and buccal mucous membranes* are sometimes the seat of extreme and most distressing hyperæsthesia. The affected parts may appear quite natural, or at most there may be undue redness and insufficient development of epithelium, giving a "beefsteak" appearance, but not at all more than I have often seen in patients who were quite free from this hyperæsthesia. The following case is a good example of this happily unfrequent disorder. Mrs. C., aged 73, was seen August 28th, 1866. She had been suffering the last five weeks with her mouth, which was so tender that she could bear nothing in the way of food but lukewarm milk and sopped bread. Cold things gave her pain as well as hot. The buccal membrane was very red, especially that of the lower lip. The whole surface, including that of the tongue, was extremely tender; but I saw nowhere any breach of surface, nor anything resembling an ulcer. There were certainly some superficial fissures on the dorsum, but they were no more than often exist without causing any suffering, and they did not appear to involve the corium. The tongue was perfectly clean and moist. Pressure on the mucous membrane did not render a spot pale even for

an instant after its removal. The bowels were regular; pulse 84, of good force. The appetite was very good, but she felt quite exhausted from being unable to take food. She got very little sleep, from the distress caused by her mouth. She had suffered much from rheumatism, and felt the changes of the weather very much. My notes extend over more than four months, and show scarce any change to have occurred during the whole of that time; and I am tolerably certain that she continued to suffer in the same way, though less severely, to the close of her life, or till about April, 1869. She constantly kept a piece of soft rag in her mouth, which afforded her some solace. On one occasion I took the temperature of her mouth, and found it as high as 100.4 deg. F. The membrane of the buccal cavity always presented the same appearance of considerable hyperæmia. At one time a little eczematoid eruption appeared at the margin of the lips, but it never extended internally. The suffering she endured must have been terrible; she described it as that caused by a burning fire, and declared she was enduring a living death. Her temperament was by no means excitable, and I do not think she exaggerated her griefs in the least. Many remedies were used; but none were of material efficacy, except a nightly opiate to procure sleep. The pathological condition was, I believe, one of neuralgia and hyperæsthesia, blended, as sometimes happens, with vaso-motor paralysis, which latter produced the hyperæmia. The neurosis may have been of gouty origin.

3. The *throat* is liable to suffer with such disorder as we are considering, which it is important not to confound with common inflammatory, as the treatment required is materially different. The following case is an illustration. Mrs. N., a young-looking, recently married woman, was seen by me on September 8th. She had been suffering four days with swelling and neuralgia of the right side of the face. Her throat had become sore, so that she had much difficulty in swallowing. On the previous day she could not get down a piece of sopped bread. There was some nausea and vomiting. The throat appeared normal, but with the laryngoscope I could see that the laryngeal membrane was much congested. Her voice, however, was not altered. She had soreness and tenderness at the sides of the neck, lower down on each side than the tonsils. She expectorated a little reddish mucus. She had some difficulty in getting her breath. Her sleep was disturbed; she woke up restless and feverish. She felt very weak. The urine appeared normal. I advised diligent steaming of the throat, sinapisms to the sides of the neck, fifteen grains of chloral at bedtime, and two grains of iodide of potassium and an ounce of effervescing mixture of citrate of potash three times a day. On the 9th she slept two hours with the chloral, then woke in great uneasiness, and only dozed the rest of the night. At noon I found her suffering much. The throat was very sore. She had not been relieved at all by the steaming; swallowing was very painful. She had much pain and tenderness in her neck; more, however, at the sides of the muscular part than in the larynx, which I could handle and move pretty freely. Her throat felt dry. Tongue coated; pulse 93. I ordered twenty grains of muriate of ammonia with ten minims of tincture of belladonna in water every four hours, hot fomentations to the neck, and aconite liniment. She also had immediately fifteen minims of chlorodyne, which gave her two hours' sleep; and at 9 P.M. I found her decidedly better, though she had a good deal of strange pain, hardly describable, on both sides of her head. The dose of chlorodyne was repeated at 10 P.M., and in the course of the night she had fifteen grains of chloral; but she was in high fever and delirium all night long. The room seemed whirling round; she felt as if she must get up and go out —as if she should fly. She saw numbers of persons in the room, with great heads and little bodies, &c. At 9.30 A.M. on the 10th, when I saw her, her throat was much better; she took some toast. The catamenia had reappeared, which had stopped, after a day of normal continuance, on September 3d. I ordered a drachm of tincture of cinchona flava four

times a day. On the 11th the throat was much better; she had still dysæsthesiæ about the head, and a large patch of urticarious erythema had appeared about each elbow. On the 12th she was so well as to call on me and take her leave before setting out for the North. She had sweated copiously the preceding night, had a good deal of eruption on the legs and thighs, but made no complaint of her throat. The attendant neuralgia, the peculiar distress, the nocturnal delirium, the urticaria, and the "juvantia," all go to prove the neurotic character of the disorder, and that it was no common sore-throat, but one where the hyperæsthetic greatly predominated over the inflammatory element. The abrupt cessation of the catamenial flow may have had to do with the supervention of the disorder; but I think the most essential factor was influenza.

4. From the throat we descend to the *stomach;* and among the woes of this much-enduring organ we may well expect to find hyperæsthesia. In fact, this condition, in a greater or less degree, is of very frequent occurrence, and constitutes the chief disorder in those cases to which the term "irritative dyspepsia" is appropriate. In many of these, hyperæmia and catarrh exist also, but as secondary complications rather than as primary maladies. The hyperæsthesia, I believe, as a paralytic neurosis, is prone to implicate the vaso-motor nerves, and impair the tone of arteries and the retentive power of capillaries. Such disorder may be simple—*i. e.*, dependent on the state of the general nervous system; or it may depend on reflex irritation, as in pregnancy. In some of these states pain is the more predominant symptom; in others, vomiting; in others, both are present in a marked degree. Andral relates a case where the tongue was natural, and the patient distressed by a very acute hunger; but the lightest food given to her was thrown up by vomiting, or, if it was retained, caused indescribable suffering. The hyperæsthesia was overcome by cold affusion and persevering administration of food. Here the disorder was simple; and such seems to be generally the case, though, in some instances, as in the hyperæsthesia of pregnancy, the influence of reflex irritation is evident. Nitrate of silver is a really valuable remedy in cases where pain is distressing; and, as it need only be given for a short time, you run no risk of spoiling your patient's complexion. It may be seconded, however, or replaced, very frequently, by subcutaneous opiates. I have employed them myself with the best effects. Dr. Clifford Allbutt writes strongly in their praise. One of his cases was that of a merchant who regarded himself as a hopeless dyspeptic, dreaded his meals, and especially his nights. He was cured (at least for the time) by one-fifth of a grain of morphia subcutaneously at 3 P.M. and 10½ P.M., followed by rest, during ten days, with one-fourth of a grain at night only for ten days more. I prefer myself to make these injections at the epigastrium, but this is not necessary. When the hyperæsthesia expresses itself in immediate vomiting without severe pain, I have great faith in strychnia, administered in doses of one-twentieth of a grain in not more than half an ounce of water. Let me cite the following instance. A slight-made female, aged 22, married four months, subject to indigestion, and weakened by a miscarriage, was brought to me with severe sickness of ten days' duration, no food having been retained the last three. I gave her, in my room, one-twentieth of a grain of strychnia, and made her lie down. After she had retched a few times ineffectually, she became much better, "did not feel at all sick," and took successively four teaspoonfuls of milk before she left. I saw her again in ten days, when she was greatly better, had only been sick once, and was able to take chicken.

5. That the *tracheal* and *bronchial* mucous surface is liable to hyperæsthesia, cannot be doubted. There are coughs of the most vexatious and obstinate character, which are either unattended with *râles* or expectoration, or where these are out of all proportion insignificant to the severity of the cough. Some of them are of reflex origin, as in Graves's case, where the expulsion of a tænia put an end to a most violent cough, that went on

night and day, and resisted all remedies. Some are due to toxic matters in the blood, as is probably the case in pertussis, and in some cases of gout, where, as Graves says, the cough is dry, annoying, and often very obstinate. Some, again, are simple neuroses, as in the case related by Trousseau, of a young lady who was of an hysterical constitution, but was exempt from catamenial irregularity, and from the nerve disorders, except a continual cough, which proved refractory to all remedies, but yielded immediately to change of air. The treatment which appears to me most rational and satisfactory in pertussis is that recommended by Dr. E. Smith, of producing and maintaining moderate narcosis by means of small doses of morphia; and this is quite accordant with the view that the paroxysms depend upon a specific toxic hyperæsthesia. There is another form of bronchial hyperæsthesia with which it is very important for you to be acquainted—viz., that which occurs in certain instances of pneumonia, where after a time the respiration becomes inordinately frequent, perhaps 80 in the minute, without any corresponding increase in the pulmonary lesions or lividity of face. In these cases the hurry of respiration is a mere neurosis, and yields to opium and a due amount of support.

6. The *heart* enjoys no exemption from hyperæsthesia. Cases are not at all rare where there is more or less præcordial uneasiness or pain, with rapid, vivid action of the heart, unduly forcible impulse against the chest-wall, and loud, sharp sounds. The radial pulse may be small and weak, contrasting strongly with the apparently forcible efforts of the heart. Such diseases are often seen in young persons, and are sometimes mistaken for instances of cardiac hypertrophy; from which, however, you may easily distinguish them by observing that the dulness-area is not increased, and the apex-beat not lowered nor displaced to the left. Toxic agents, such as tea and tobacco, reflex irritations, as of the gastric mucous surface, and primary failure or disorder of nerve-force, may all be incriminated in different instances as efficient causes. In the latter group, it seems most probable that the nervous filaments distributed to the endocardium are unduly impressible, and, being thus over-stimulated by the moving blood, keep the muscular fibres in a state of rapid action. Anæmia, though a very common cause, is by no means necessarily present. In Da Costa's account of the curious cardiac malady frequent among American soldiers in the late war, he mentions, as symptoms, constantly recurring attacks of palpitation and pain, whose chief seat is near the apex of the heart, and combined very commonly with excessive cutaneous sensibility. In some of his cases the disorder supervened on fatiguing marches; in others it occurred after fevers or diarrhœa. He tells us in his recent paper (*American Journal of the Medical Sciences*, January 1871) that digitalis or digitaline had more influence on the cardiac disorder than any other drug resorted to. Belladonna internally he also found a most efficient agent, particularly valuable in instances of irregular action. Aconite reduced the force of the heart, and lessened the tension of the pulse; it was most suited to cases of commencing hypertrophy. No special commendation is bestowed on other sedatives; and gelsemin, which is reputed to be a cardiac sedative, disappointed him much; for the most part, it had no effect at all. Morphia hypodermically relieved the cardiac pain almost invariably, and so did atropia; but the effect was only temporary. Tonics were often most excellent adjuncts to treatment, but availed little by themselves. Zinc and iron accomplished most. Da Costa's experience has convinced him that there is a real connection between the functional disorder, cardiac irritability, and the organic one, cardiac hypertrophy; that, in fact, "the one grew out of the other." Dr. Walshe admitted the same connection several years ago. I cannot refuse to admit the doctrine held by these high authorities; but my own experience would not lead me to rate this cause of hypertrophy highly. I am sure that a weak and irritable heart may simulate very much a condition of hypertrophy, and yet, under suitable treatment, subside into a condition apparently healthy.

A belladonna plaster is a remedy that generally does good service, and is to be preferred, I think, in most cases, to the subcutaneous opiate, which, in two cases where I tried it, produced more syncope than was at all agreeable to witness. Dr. Clifford Allbutt, however, assures us that subcutaneous injection of morphia in small doses is very valuable in so-called irritable heart, whether this be due to weakness of the organ or instability of its nerves. The first dose administered in this way should not exceed one-tenth of a grain.

7. A sort of diarrhœa which I have occasionally met with in elderly persons, seems to me attributable with much probability to hyperæsthesia of the *mucous lining of the rectum*. The feces appear natural enough in all respects; but the lower bowel is intolerant of their presence, and, in a fidgety, petulant manner, insists on expelling them much more frequently than is at all convenient. Belladonna has appeared to me of some service in this condition of things, and still more, perhaps, cold sponging of the anus directly after defecation.

8. Nocturnal incontinence of urine is an instance of hyperæsthesia affecting the *bladder*, to which it may be sufficient to allude. Let me, however, add that recently Dr. Barclay has praised syrup of iodide of iron as unfailing in this disorder. Belladonna in gradually increasing doses, you know, is the most approved remedy; but there is no reason why both should not be employed. A tonic will sometimes quell hyperæsthesia better than a sedative. Hyperæsthesia of the *urethral lining* is a marked feature in many cases of spermatorrhœa, and its removal by means of repeated catheterization is reputed beneficial.

9. Hyperæsthesia of the *testis* is a very distressing neurosis; it reacts very injuriously upon the mind, and has in several instances induced sufferers to insist on the removal of the affected organ, which in three cases was found healthy by Sir A. Cooper. He considers it of centric origin; but it may be of reflex peripheral origin, as in the following case. A. C., aged 23, was admitted Nov. 13th, 1870. He was in good health until five days previously, when he was suddenly taken with pain in the left testis; it was severe, and the testes began to swell. In a day or two the right became painful also. These symptoms were succeeded by pain in the loins and head. The pain now affected him only when he stood up, or when the testes were pressed. There was very little swelling of either testis. He had some tenderness of the hypogastric region, and a good deal of straining at stool. He had no sleep at night. Temperature 103.5 deg.; pulse 80. He had thirst and anorexia. On the 15th he experienced a kind of tearing sensation at both external abdominal rings, going down into the testes. On the 16th the temperature was 97,2 deg.; pulse 60, weak. The bowels had not been open since admission. His extremities became very cold the previous night; and he then became very hot and burning, and afterwards perspired profusely. He could not stand without support; the room and everything appeared to turn round with him. His testes were small, soft, very tender when touched, and the pain shot up along the cords. The bowels were now well opened by castor oil, and afterwards an opium suppository of one grain was introduced. The testes ceased to be painful about four hours after the bowels acted, before he had the suppository. On the 17th they bore handling well; he was also less giddy, could walk, but not very steadily. He had no pain anywhere. He was now taking tincture of cinchona and carbonate of iron, and by the 23d was getting quite well. The hyperæsthesia and pain of the testes in this instance were mainly dependent on the irritation caused by feces in the lower bowel; but the action of this cause was probably much promoted by the existence of influenza enfeebling the nervous system.

10. We should be disposed, *a priori*, to expect that an organ with such extensive and powerful sympathies as the *uterus*, would be prone to suffer from sensory disorder, and such appears to be the case. The affection originally termed "irritable uterus" by Dr. Gooch is regarded by him,

Churchill, Mackenzie, Tilt, and Ferguson as essentially a neurosis. The latter expressly says "the local changes have been the fluctuating, the nervous affection the constant, element." The tenderness is so great and constant that great suffering is experienced if the patient incautiously sit down upon a hard seat, or if coition be attempted. One of the seats of this neuralgic malady is the vagina itself, which is so exquisitely tender as to render intercourse intolerable. Here I think we cannot fail to recognize hyperæsthesia as the essential morbid element—at least if we accept the *dictum* of Dr. Ferguson above cited, confirmed as it is by Churchill's authority, to the effect that in the cases seen by him there was no ground whatever for the supposition of inflammatory action. Associated with hyperæsthesia, there may be, as we have before seen, more or less of hyperæmia, and inflammatory congestion; but this is not in any degree the cause of the sensitiveness. Dr. Mackenzie's statement is of practical importance, that this neurosis may be of reflex origin, and dependent on gastro-intestinal irritation. In most cases, however, it seems to be primary, and to result from some cause of nerve-exhaustion, as great fatigue, acting, no doubt, on a weakly organized nervous system. The *retentissement* of this neurosis on the higher centres seems to be very pernicious; the natural emotions and faculties become miserably perverted, and all nobility of character is lost in absorbing selfishness. Sedatives, locally applied by pessary or enema, subcutaneous injections, and tonics, are our best pharmaceutical remedies; but change of scene and place, and a suitable climate, may be still more important.

11. Hyperæsthesia of the *female breast*, attended with more enlargement, is a well-known phenomenon. It may suffice for me to have named it, and to cite Mr. Erichsen's authority for its not being unfrequently dependent on uterine irritation.

12. Hyperæsthesia *of the joints* is well known to surgeons since the publication of Sir B. Brodie's work on local hysterical affections, which I advise you all to read. The most constant symptom is morbid sensibility of the joints and adjacent parts, which is associated sometimes with more or less general tumefaction, apparently from a turgid state of the small vessels. I have known a condition of this kind, attended with sanguineous vomiting, yield to carbonate of iron, after an offer of amputation had been (fortunately) declined. I hope none of you will ever make such a *faux pas*.

13. As regards the nerves of special sense, I cannot doubt—taking first the *optic*—that even putting aside the case of strumous ophthalmia, where it might be contended that the photophobia was dependent on irritation of the filaments of the fifth nerve distributed to the cornea, there is really such a disorder as retinal hyperæsthesia. Mr. Soelberg Wells states that in this affection there is intense photophobia, though the eye is quite normal. There is often great ciliary neuralgia, the pain extending to the face and corresponding side of the head. One point which he mentions appears to me of especial interest—viz, that the peripheral portion of the retina is anæsthetic, while in the central vision is perfect and hypersensitive. This is very indicative of the true character of the disorder, of its affinity to paralysis. The causes are such as impair the general health or strain the retina; and the correct treatment is to rest and soothe and recreate nerve-power.

The *auditory nerve* also is liable to hyperæsthesia. Sir T. Watson mentions having observed this in a man moribund from cholera. Dr. Russell Reynolds affirms that hysteric girls do sometimes seem to hear through stone-walls. Intolerance of sound is an occasional symptom in the early period of meningitis, and is not unfrequent in nervous headache, and in azoturic sufferers. The only thing common to these various conditions is a lower degree of vital power.

14. That the *cerebrum*—the great centre where impressions are consummated into perception—is liable to pass into a state closely analogous to that of a tertiary centre and sensory nerve when these are

hyperæsthetic, seems to me not doubtful. Gooch mentions the case of a deranged lady, whose prominent belief was that her husband was unfaithful to her. The notion, so far from being unreasonable, was, he believed, true, and she had known it for many years without any unnatural disquietude, but now it engrossed all her thoughts. She neglected her ordinary pursuits, took a dislike to her friends, felt no interest about her children, and sat silent and motionless from morning to night. After continuing deranged several months she recovered, although she retained the same opinion. Gooch justly says her insanity consisted not in her ruling idea, but in its overwhelming influence over her feelings and conduct. A modern pathologist would probably express this by saying that her brain had become enfeebled and hyperæsthetic, and was, therefore, intolerant of the idea it had previously endured. The following occurrence is similar. A religious student, who was much harassed by petty scruples and fancies, and well aware of their pernicious effect, observed after a time that he was always more plagued by them while preparing for an examination; *i. e.*, when his cerebral power was most exhausted. The essence of hypochondriasis seems to be a special hyperæsthesia to corporeal impressions emanating *ab interno*. How much the tyranny of these may depend on enfeeblement of the great centres, is shown by P. Frank's account of his own sufferings from the dread of aneurism, induced by mental exertion, and removed by recreation. This is much too large a subject for me to attempt to handle now: all I can do is to commend to your attention the notion of cerebral hyperæsthesia as essential to the due comprehension of many common phenomena.

How far the *seat* of the action giving rise to hyperæsthesia may be purely peripheral, is difficult to say. In the great majority of instances some nervous centre is probably engaged; but some facts—such as the removal of severe neuralgia for some months after section of the nerve, and the cessation of suffering after amputation of the testis—incline me to believe that the morbid action may have its chief *locus* at the periphery, and that without any apparent structural change in the affected part.

Pathological Change in Hyperæsthesia.—You may be disposed to ask me what this is. I wish I could tell you; but our knowledge of this matter is very scanty. All that we can say is, that it is undoubtedly a condition of imperfect nutrition, inasmuch as it may be generated by deprivation of blood, by injuries to nerves, by miasms in the blood, by remote irritation—in short, by all sorts of things that are injurious. Some particulars under these heads deserve to be mentioned. Hyperæsthesia of the most intense kind is produced sometimes by obstruction of the arteries with fibrinous deposit. Dr. Fuller describes a case where the first symptom was acute pain, associated with such exquisite tenderness of the whole limb that the slightest touch caused intolerable suffering. The hyperæsthesia continued until mortification set in. At the necropsy, all the larger arterial trunks, from the iliacs downwards, were found blocked up by firm, light-coloured coagula of long standing. No other cause existed for the hyperæsthesia in this case, except the deprivation of blood. In Dr. Waller's experiments on refrigeration of the ulnar nerve, the ultimate effect produced was anæsthesia in the course of the nerve; but this was preceded by hyperæsthesia. It can scarcely be thought that the latter was, under the circumstances, anything but the first stage of the former; and, therefore, the conclusion seems necessary that it implies not an exaltation, but a deterioration of vital power. Again, there is a case on record where, during the gradual recovery of the brachial plexus from an injury, the skin of the upper part of the arm possessed natural sensibility, another (probably the mid-part) was morbidly sensible, while that immediately beyond was quite insensible. Here, again, the conclusion seems inevitable that hyperæsthesia implies a damaged state of nerve-tissue, though not so severe as that which exists in anæsthesia. Much other clinical observation is to the same effect; the

same morbid alteration of sensibility (cutaneous) is met with in typhus and typhoid fever, in influenza, in rickets, and in epidemic cerebro-spinal meningitis. On the other hand, there is not the least proof that real increase of functional energy renders an organ less tolerant of its natural stimuli: in fact, the evidence tends quite the other way. A vulture's eye, which can discern a carcass at an extraordinary distance, can easily endure the full blaze of tropical daylight, and is evidently altogether in a different condition from the eye of a photophobic invalid. Several similar instances might be cited; and, on the whole, the general truth of the view here taken seems to me established. In a recent lecture on Experimental Physiology, in the *Lancet*, February 11th, 1871, Dr. Rutherford has noticed this point without explaining it. He says, "the curious point is, that a nerve whose nutrition is to some extent defective should discharge its energy more readily than one whose nutrition is perfect." In what respect defective nutrition changes the nerve-tissue, I have said we cannot tell; but we may, I think, exclude œdema; for Buhl affirms as the result of his observations of continued fever, that the presence of much fluid in the subarachnoid and ventricular spaces corresponds with stupor or unconsciousness. Patients dying of delirium tremens have commonly wet brains, and they die for the most part in stupor. However, if we adopt, as I am much inclined to do, Dr. McDonnell's theory of nervous action, the detection of some material change may not perhaps be the most important matter. He assumes that the various impressions are propagated by undulations, the wave-length of which varies, so that the same conductor may be able to transmit several impressions. Now, on this view, it might be that undulations of a certain length and rapidity produced normal sensation, those of a less extent gave rise to hyperæsthesia, while a still further reduction of the undulations caused pain, and their total arrest, anæsthesia. This may seem the more probable, as there is undoubtedly a close connection between the three just mentioned morbid states. They often occur together, acknowledge the same causes, and are removed by the same remedies. Another connection of hyperæsthesia is less frequent, but is extremely well marked in rickets, viz., that with vaso-motor paralysis. I use the latter term hypothetically, for the phenomena actually observed are hyperæsthesia of the cutaneous surface and profuse sweating. The latter, however, as I have argued elsewhere, seems to be distinctly traceable to defective contraction of vessels from a paretic state of their nerves; and if this be so, then the connection is as I have stated. Admitting this, it is difficult to see in the hyperæsthesia anything else than a species of paralysis very similar to that which affects the vaso-motor nerves, and which may itself depend on defective molecular movement.

Allied, however, as these morbid states are, there are differences between them, which are important as regards treatment; thus anæsthesia is more connected with prostration, and is more benefited by stimulants, than hyperæsthesia is. The latter is sometimes intolerant of these, and yields better to remedies of the sedative class. Thus in a state of pain with anæsthesia, bark, ammonia, and wine suggest themselves; whereas if hyperæsthesia be in the ascendant, bromide of potassium or chloral, or subcutaneous opiates seem more hopeful remedies. Yet we must not strain this rule, for it admits of numerous exceptions. Neither must we ever omit a careful inquiry into the cause of the hyperæsthesia, for the knowledge of this may be all-important. It is idle to go on administering tonics or sedatives if a focus of irritation need to be removed, or if the disorder be dependent upon poisoned blood. Here is much room for the exercise of *real* diagnostic skill, not that which contents itself with affixing a name to a given case of disease.—*Brit. Med. Journ.*, Sept. 30, 1871.

HOSPITAL NOTES AND GLEANINGS.

Operations performed under the Influence of Ether at St. George's Hospital.—The numerous fatal cases following the admin-

istration of chloroform which have been recorded seem to have induced some of the London surgeons to try again *ether* as an anæsthetic agent. In the *Lancet* for Dec. 2, 1871, are recorded some cases of this kind, and it remarked: "Excepting that for harelip, all these operations were performed during anæsthesia produced by ether apparently with as much ease and rapidity as is usual with chloroform. In two cases, those of adults, in which the time was noted, insensibility was produced in five and four minutes and a half respectively. The inhaler employed by Mr. Haward consisted of a cone of felt, into which a small sponge was introduced, and which was so constructed that the ether could not drain down on to the patient's face. One child vomited some undigested food, but sickness did not occur in any of the other cases.

"The only outward difference between the administration of ether and that of chloroform appeared to be the more frequent replenishment of the inhaler, and the very appreciable extent to which the theatre became pervaded with the vapour of the anæsthetic."

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Erysipelas of the Head and Neck, with Violent Delirium, treated with Chloral.—J. M., aged 30, was admitted, Oct. 28, 1870, into St. Bartholomew's Hospital, Rochester, under the care of Mr. A. W. Nankivell, suffering from erysipelas of the head and face, resulting from a wound. The right side of his head and neck was much swollen, and his right eye entirely closed. He was at this time perfectly rational. Next day the erysipelas had extended all over the head, and down the chest as far as the mammary region. He had a quiet night. In the afternoon he became delirious, and had 30 grains of chloral at 5.35 P.M.; 40 grains at 6.10 P.M.; 20 grains at 7 P.M.; 30 grains at 7.40; 20 grains at 8.15; 20 grains at 8 30 (he spat it nearly all out, swallowing about 5 grains); 20 grains at 8.45 (of which he only swallowed about 5 grains); 20 grains at 9 P.M. (of which he swallowed about 10 grains). At 9.45 P.M. he was quieter; 30 grains of chloral were put into his mouth, and he swallowed about 15 grains. At 10.45 P.M. he refused all medicine, and 40 grains of chloral mixed with milk were injected into the rectum. At 11.40 P.M., after much persuasion, the patient was induced to take some beef-tea containing 40 grains of chloral. A few minutes after taking the last dose, the man fell asleep till 2 A.M. When seen next morning, he was found to be rather noisy, but quite ready to take food. He was given 30 grains of chloral in the course of the day, after which he slept for three hours. After this date, the man progressed favourably, with the exception that a large part of the skin of the right side of the neck sloughed, and, in consequence, the resulting ulcer took a long time to heal. We, however, managed to accelerate the healing materially by skin-grafting.

My object in bringing this case before you is to show the large amount of chloral that was taken in a short time without any bad results. The chloral was first administered on October 29th, at 5.35 P.M. The last dose before sleep was induced at 11.40 P.M. During the interval of six hours and five minutes, the patient took as much as 255 grains. As far as I have been able to discover, this is the largest amount of chloral given in so short a time.—*Brit. Med. Journal*, Oct. 14, 1871.

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Injury to Cervical Vertebræ; Anchylosis of the Atlas to the Occipital Bone; Dislocation of the Axis; Death.—A labourer, æt. 37, in a row, Dec. 24 1870, fell headlong down a flight of stairs. He went to his lodgings, and complained of a stiffness of the neck. He resumed his work in the course of a few days, and continued it till February 23, 1871. During this time, his fellow-labourers noticed that he was scarcely able to rotate his head. On February 24 he stated that he did not feel quite well, and would take a few days' rest. This he did. February 26 he was found by his fellow-labourers to be much worse, being quite unable to walk. He was admitted on that day into St. Bartholomew's Hospital, Rochester, when his arms and legs were found to be completely paralyzed. The muscles did not

respond to galvanism. He could swallow with difficulty, and could not speak above a whisper. He died in three-quarters of an hour.

A post-mortem examination was made twenty-four hours after death. Rigor mortis was well marked. The patient was a well-nourished, strong, healthy working-man. The pleura, lungs, pericardium, heart, liver, and spleen were slightly congested. The left kidney contained numerous cysts, communicating freely with each other, the gland being atrophied. The right kidney was hypertrophied. The brain was healthy. On dividing the medulla oblongata, a bony prominence was felt, particularly filling up the foramen magnum. The medulla was slightly softened at the seat of pressure. On removing the portion of skull and part of the cervical vertebræ (which I have here before me), we found that the projection was the odontoid process of the axis. The atlas was partially luxated from the occipital condyles, and rotated about twelve degrees, the left articular process of the atlas being thrown forward and crushed against the skull, yet without fracture. The right upper articulating process of the axis was covered with cartilage, and healthy; the left was bare of cartilage, and the corresponding surfaces of the atlas were in the same state. The ligaments were unfortunately destroyed in removing the specimen.

The interest of this case is due to the length of time that elapsed from the receipt of the injury to the occurrence of any grave symptoms, and to the rapidity with which death came on after the commencement of the fatal symptoms. So rapid a death appears, in all probability, to have been caused by some sudden giving way of some of the ligaments, thus allowing the odontoid process to slip up into the foramen magnum, and so cause the paralysis.—*British Med. Journal*, Oct. 14, 1871.

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Atrophy of the Optic Disk.—In a recent clinical lecture on this subject (*Med. Times and Gaz.*, Nov. 18, 1871) Prof. Liebreich stated that to obtain the proper diagnostic observations it is necessary to examine the direct image. For that purpose you must be placed close to the eye of the patient, adapting behind the mirror concave glasses of such a power as is required by the short-sightedness of the eye of the patient, or of that of your own.

In order to be able to examine the direct image without artificial dilatation of the pupil, it is necessary to use a mirror with a sufficiently small and carefully worked hole in the centre. If the hole is nearly as large as the pupil of the patient, it is impossible to throw light enough into his eye. If the margin is irregular, containing little scratches, or if it forms a channel instead of a sharp ring, the reflex of light proceeding from this border puzzles the observer by producing entoptic phenomena in his own eye. A very small part of the mirror only throws light into the pupil—namely, that which immediately surrounds the hole. It is therefore quite useless to use very large mirrors, which are tiresome to the patient, without giving a stronger light to the part of the fundus under observation.

Since I gave these explanations, the diminution of the mirror and its central hole has often been made too great. If the mirror is too small, it cannot well be put against the supra-orbital margin, and insufficiently protects the observer against the flame. Too small a hole has two great inconveniences: at first it diminishes the intensity of the light, allowing only too small a pencil of light to pass from the observed to the observer; secondly, it acts as a stenopaic apparatus, and deprives us of our judgment on the refraction of the patient by suppressing the circles of dispersion.

I therefore propose to make the hole not smaller than two millimetres, and the mirror not smaller than three centimetres, and to use in preference a thin silvered glass mirror, the centre of which is not perforated, but only deprived of the silver covering. The focus of the mirror may be of eight or ten inches.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Death attributed to Chloroform.—In Circular No. 3, Surgeon-General's Office, recently issued, we find reported the following case of death ascribed to chloroform. H. J., a private of Co. E, 19th Coloured Troops, aged 20 years, had his thigh fractured by a conoidal musket-bullet accidentally fired. Two months and a half after the receipt of the injury, chloroform and ether were administered for the purpose of excising the ends of the bone. The patient inhaled two minutes, then began to sink; pulse failed; spasms occurred; the head was drawn back, and hands and feet were in a tremor. The sponge was removed and the patient rallied, but as soon as the sponge was reapplied the spasms returned, the pulse stopped, and death supervened.

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Association of Medical Superintendents of American Institutions for the Insane.—This active association held its twenty-fifth annual meeting in Toronto, Canada, on the 6th, 7th, 8th, and 9th of June, 1871. As usual, there were many interesting papers read and very instructively discussed, a report of all which will be found in the *American Journal of Insanity* for October last.

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Smallpox Mortality.—The mortality from smallpox in Philadelphia during the past four weeks has been as follows:—

	Deaths.
Week ending December 2	233
" " " 9	199
" " " 16	211
" " " 23	228

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Literary Piracy.—The editor of the *Lancet*, in his number for Oct. 28th, complains greatly of the republication of English medical works in this country, and asserts that "the retort that we publish American works has no foundation in fact." We are not disposed to entirely deny the justice of the editor's complaints, but we think it would not be difficult to prove that our English cousins are not quite so immaculate as is claimed. It may be bad enough to republish without proper authority English works, even when the author's name is given on the title-page and in the preface, by which at least his reputation is extended and some recompense in the way of fame secured to him. But this is not always the only compensation awarded to English authors. We happen to know, so far at least as one publisher is concerned, that his republications are usually made through an arrangement with the English publisher or with the author, and we have seen numerous letters from the latter acknowledging the courtesy extended for the pecuniary remittance spontaneously sent to them for the use of their labours. But what can be said when an American work is republished in England, and instead of the author's own name being placed on the title-page, that of another is substituted for it. And yet something very like this has occurred quite recently. We have before us a volume published within a year, entitled "*The Medical Jurisprudence of Insanity*, by J. H. Balfour Browne, Esq., Barrister."

In a review of this work, published in the October No. for 1871 of the *Journal of Mental Science*, the plagiarism of which Mr. Browne has been guilty is so fully exposed, that we will content ourselves with one or two extracts from that review by one of his own countrymen.

The reviewer says: "There is one sentence in this book which strikes us as being, perhaps, the truest in it. 'Sometimes, in shabby genteel families, a coat which was once worn by the father is adapted to the eldest son, and from him passes to a younger brother. So it is often in books; and some recent writers upon the medical jurisprudence of insanity have been much indebted to their predecessors.' We do not know who the writers are to whom Mr. Browne alludes, but we know that in this respect he is a sinner above all others with whom we are acquainted." * * *

"The author has taken as his model and guide the well-known work of Dr. Isaac Ray, and has followed this so closely that his own book might almost be called

a new edition of Ray, brought up by means of a few modern cases to the present time."

To prove this, the reviewer gives the table of contents of the two works side by side, and remarks :—

"If any one will examine these two tables, he will see that they correspond most closely, while some of the divisions, as Intellectual Mania, general and partial, and partial and general Moral Mania, are quite peculiar to Dr. Ray, and, so far as we are aware, have been adopted by no other author, yet Mr. Browne gives them as his own without the least acknowledgment."

FOREIGN INTELLIGENCE.

Deaths from Chloroform.—A case of this occurred recently at the London Hospital. The subject of it was an iron merchant, æt. 33, upon whose left foot a piece of iron fell. It was found that the first and second toes were fractured. Amputation of the toes was considered necessary. The deceased having undergone the necessary previous examination, chloroform was administered to him ; but at first he resisted it, being in a state of excitement. The amputation was proceeded with, when it was found that the pulse had ceased. Remedies were at once used to restore the patient, but life was quite extinct.—*British Med. Journal*, Nov. 25, 1871.

In the *Boston Med. and Surgical Journal* for Dec. 14, 1871, it is stated that there is reported in the *Australian Med. Gazette* for July, 1871, the case of a female, aged 48, to whom chloroform was administered for an operation on the knee. Less than a drachm had been used when death ensued.

Dr. Pirrie communicates another case to the *British Med. Journ.*, July 29, 1871 : A man, aged 37, was brought into the theatre of the Aberdeen Royal Infirmary for the purpose of being operated upon for the radical cure of hernia. Chloroform was administered on a towel. Just as the preliminary incision had been made attention was called to the alarming appearance of the patient, whose pulse and breathing had suddenly ceased. Artificial respiration was tried without effect. On post-mortem examination the walls of the heart were found to be flaccid, the walls of the left ventricle and the septum cordis were in an advanced stage of fatty degeneration.

Still another case is recorded (*Brit. Med. Journ.*, Dec. 2, 1871), occurring in a healthy man, aged 53, who was admitted into the London Hospital, with a foot crushed by a piece of iron falling on it. It was found necessary to amputate the first toe, and chloroform was administered on a fold of lint, and for about five minutes seemed to produce no effect. The patient then suddenly became excited, and the administration of the chloroform had to be desisted from. He continued excited for about two minutes, and then became quiet. He screwed up his eyes when the conjunctivæ were touched. The operation was now commenced, and he winced at the first prick of the knife. The pulse now began to beat very feebly, and almost immediately afterwards stopped. The man breathed more than once after the heart and pulse had ceased to be felt. Artificial respiration and the interrupted current were used without avail. At the *necropsy* the heart-fibres were found to be granular and contained some fat-globules.

Iodized Cotton.—M. Méhu, pharmacien at the Necker Hospital, describes his mode of impregnating cotton with iodine. The iodine is first reduced to an extremely fine powder by trituration in a porcelain mortar, its pulverization being greatly facilitated by adding, from time to time, some drops of ether. Very fine and quite dry carded cotton should be chosen, its weight being ten times greater than that of the iodine. This is introduced in small portions, with the proportion of iodine, into a flask capable of containing a litre, and having a wide mouth. Into such a flask from twenty to twenty-five grammes of the cotton are sufficient to be introduced, in order to secure its thorough permeation by the iodine. The flask is placed in a sand-bath, only slightly corked, until the heated air has escaped, when it should be closely stopped. The iodine disen-

gaged now thoroughly permeates the cotton, and when this has attained the colour of roasted coffee the process is finished. As much as 10 per cent. of iodine may be thus combined, but for all ordinary purposes 5 per cent. suffices. The cotton may be prepared, also, in a boiling water bath. To preserve it for use it must be kept in a bottle stopped with emery or by a cork which has been long kept in melted paraffine. This cotton has been found very useful applied to glandular swellings of the neck, or wherever the local use of iodine is indicated—placing it round the neck, for example, and securing it by a bandage. It requires to be renewed every two or three days.—*Med. Times and Gaz.*, Sept. 16, 1871.

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Influence of Insufficient Food on Women's Milk.—M. Decaisne, taking advantage of the siege of Paris, instituted a series of carefully conducted experiments on forty-three women to determine this point.

The following are his conclusions:—

"1. That the effect of insufficient food on the composition of woman's milk presents great analogy with that observed in the case of animals.

"2. That these effects vary according to constitution, age, hygienic conditions, etc.

"3. That insufficient food always gives rise, within varying proportions, to a diminution in the amount of the butter, caseine, sugar, and salts, whilst it augments generally that of the albumen.

"4. That in three-fourths of the cases observed the proportion of the albumen is in an inverse ratio to that of the caseine under an insufficient diet.

"5. That the modifications in the composition of the milk due to a reparative diet always manifest themselves in a striking manner by the end of four or five days."—*Ibid.*, Nov. 25, 1871.

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Antidote to Carbolic Acid.—Dr. T. Hasemann, from numerous careful experiments, both chemical and medicinal, advocates the use of a strong solution of saccharate of lime, of course to be taken as soon as possible, as an antidote to carbolic acid.

Oiling the Urethra.—Mr. Barrett recommends (*Lancet*, Nov. 11, 1871) oiling the urethra instead of the catheter when introducing the latter, in cases of retention of urine. This he effects by injecting oil into the urethra with a syringe, compressing, at the time, the end of the penis firmly between the thumb and finger of the left hand, and continuing the pressure until the point of the catheter is inserted. This plan is not new, having been described by Sir Henry Thompson some years since.

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Refrigeration of Warm-blooded Animals.—Dr. Horvath reports (*Centralblatt*, No. 34) some interesting results attained by him in experiments on the refrigeration of warm-blooded animals. 1. Refrigeration was carried to such a degree in a young dog that the temperature in the rectum descended to 6.6°, 5.8°, and even to 4.8° C. (44° to 40° F.), and yet the animal, on the reapplication of heat, revived, being then apparently in much the same condition as before the refrigeration. As far as Dr. Horvath is aware, no one had hitherto seen a warm-blooded animal restored to life after such a reduction of temperature. 2. In other experiments he has reduced the temperature (in the rectum) of a rabbit to 7° C. (45° F.), and of a cat to 9.5° C. (49° F.), and found that neither the action of the heart nor the respiratory movements could be perceived. Nor did even the strongest electrical current exert the slightest effect either upon the muscles of the skeleton or directly upon exposed nerves. On the restoration of warmth, by pouring warm water over these animals, which had remained for an hour in a state of apparent death, spontaneous contractions of the heart, which had ceased for an hour, were observed. The electrical current, also, applied directly to the muscles, induced energetic contractions in the same muscles which, before the warmth was applied, were insensible to the strongest electrical action. 3. A third interesting and not less important fact is, that in an animal which was first refrigerated and then warmed, it was not possible to excite the action of the muscles of the skeleton by even the

strongest electrical stimulus when applied to their nerves, while these same muscles, on the direct application of the current, contracted energetically. The fact that we can separate nervous and muscular energy from each other by this agency, which hitherto it has only been possible to do by the employment of curare, promises to be of good service in future researches concerning the physiology of the muscular and nervous system.—*Med. T. and Gaz.*, Sept. 16, 1871.

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Invention of Enema-Apparatus.—We referred lately, on German authority, to the astonishment of the Bavarian soldiers at the ubiquity of the "irrigateur" in French establishments, and the odd uses to which they put them. Frederigo Kernot, of Naples, in a newly published *Storia della Farmacia*, describes "with true southern liveliness," according to the *Pharmaceutical Journal*, the invention of the enema-apparatus, which he looks upon as an epoch in pharmacy as important as the discovery of America in the history of human civilization. The glory of the invention of this instrument, so beneficial to suffering mankind, belongs to an Italian, Gatenaria, whose name ought to find a modest place together with Columbus, Galileo, Gioja, and other eminent and illustrious Italians; he was a compatriot of Columbus and professor at Pavia, where he died in 1496, having spent several years in the perfection of his instrument. The enema-apparatus may be justly named the queen of the world, as it has reigned without a rival for three hundred years over the whole continent, besides Brazil and America. The enema came into use soon after the invention of the apparatus itself. Bouvard, physician to Louis XIII., applied two hundred and twenty enemata to this monarch in the course of six months; in the first years of Louis XIV. it became the fashion of the day; ladies took three or four a day to keep a fresh complexion, and the dandies used as many for a white skin. Enemata were perfumed with orange, angelica, bergamot, and roses; and Mr. Kernot exclaims enthusiastically, "O! se tornasse questa moda" (oh, that this fashion would return)! The medical profession at first hailed the invention with delight, but soon found the application *infra dig.*, and handed it over to the pharmacist; but shameful invective, sarcasms, and epigrams, hurled at those who exercised the humble duty of applying the apparatus, made them at last resign it to barbers and hospital attendants. As a specimen of these epigrams, the author gives the epitaph on a tombstone of an ancient pharmacist:—

"Ci gît qui pour un quart d'écu
S'agenouillait devant un cu."

—*Brit. Med. Journal*, Sept. 23, 1871.

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Effects of Strikes on Mortality.—The Recorder of Newcastle has shown us that strikes cost the country something more than money, trouble, ill-will, and loss of trade. The privations which the artisans have to endure leave their inevitable record in the mortality amongst them, and the last Newcastle strike brought the death-rate up from 26 per 1000 to 40.—*Med. Press and Circular*, Oct. 25, 1871.

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Female Students in Prussia.—The Königsberg academical authorities having addressed a question to the Minister of Public Education (Herr von Mühler) concerning this matter, have received a reply from this dignitary which frustrates the hopes of the fair aspirants. The statutes of the University, he says, contain no provision for the case of a female student. Indeed, a like thing had not been thought of at the time of their being framed. It would therefore be necessary, he further argues, to alter the statutes, for which His Excellency, as at present advised, cannot see any cause. Then follows a categorical interdict against the admission of female persons to University lectures.—*Brit. Med. Journ.*, Aug. 19, 1871.

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Obituary Record.—Died in Paris, aged 76, the celebrated obstetrician Paul Dubois, Honorary Dean of the Faculty of Medicine, Commander of the Legion of Honour, Member of the Academy of Medicine, &c. &c. His funeral took place on the 4th of December.

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The products of a scholarly and well-stored mind, and the results of an eminently sagacious observation, expressed in language that is at once precise, perspicuous, and pure. Scholarly without being pedantic; excellent in exposition; graphic in illustration, and furnished with an honest backbone of common sense.—*London Lancet*, Oct. 28, 1871.

At length, after many months of expectation, we have the satisfaction of finding ourselves this week in possession of a revised and enlarged edition of Sir Thomas Watson's celebrated Lectures. It is a subject for congratulation and for thankfulness that Sir Thomas Watson, during a period of comparative leisure, after a long, laborious, and most honorable professional career, while retaining full possession of his high mental faculties, should have employed the opportunity to submit his lectures to a more thorough revision than was possible during the earlier and busier period of his life. Carefully passing in review some of the most intricate and important pathological and practical questions, the results of his clear insight and his calm judgment are now recorded, for the benefit of mankind, in language which, for precision, vigor, and classical eloquence, has rarely been equalled, and never surpassed. In an epilogue at the end of the second volume, the author expresses his obligations to Dr. George Johnson "for his friendly assistance in re-editing the Lectures" The revision has evidently been most carefully done, and the results appear in almost every page.—*British Medical Journal*, Oct. 14, 1871.

We have endeavored, by our extracts, and by reference to some of the more prominent subjects, to indicate the extent and the thoroughness of the revision to which these lectures have been subjected. The result is that, as a text-book on medicine, the work is unrivalled, combining, as it does, in an extraordinary degree, scientific accuracy, practical wisdom, and an unapproachable charm of style. These characteristics will insure its popularity with students and practitioners, and even with educated general readers, who never fail to appreciate a clear statement of scientific truths.—*British Medical Journal*, Oct. 21, 1871.

There is no text-book of the kind with which we are acquainted that is so healthy in its tone, so pure in its style, so graphic in its history of cases, and altogether such pleasant reading, as "Watson's Practice of Physic."—*London Lancet*, Nov. 18, 1871.

HENRY C. LEA, Philadelphia.

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CLINICS.

CLINICAL LECTURE.

Clinical Lecture on those Symptoms in Women which point to the Expediency of instituting Local Examination. By ROBERT BARNES, M.D., Obstetric Physician to St. Thomas's Hospital, etc. etc.

There is nothing special in the mode of studying the diseases of women. Just as the ophthalmic surgeon is led to examine the eye because the patient complains of loss or disturbance of its function, or because he feels pain in it, or has some other subjective symptom referred to that organ, so by disturbances of function or some other subjective sign are we led to the discovery of disease of the sexual organs. When the function of an organ is disturbed, the *primâ facie* inference is that the organ itself which constitutes the mechanism by which that function is performed is out of gear. This is not indeed always absolutely true; because an impaired state of the blood, or disordered innervation, or derangement of a different organ, may entail the functional disorder which arrests our attention. The genital organs are no exception to this proposition. The functions of the ovaries, uterus, or vagina may be seriously deranged by a state of anæmia or blood-poisoning, by disease of the nervous centres, by disease of the heart, lungs, or liver. These functions may be even more seriously affected by mechanical pressure in contiguous parts. Still the fact remains that we can hardly appreciate rightly or successfully treat these primary or correlated diseases if we do not take into careful consideration the state of the genital organs themselves. The general or distant affections require to be investigated and treated; but it is not safe to overlook the organs that may be secondarily involved.

It is needless to say that every woman who is ill and seeks advice does not suffer

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from disorder of the sexual system. She may labour under various constitutional disorders, and under disorders of parts of the body quite independent of the sexual system. On the other hand, general or local disorders may in their course react upon, and induce disorders in, the sexual system. And there are disorders of this special system, commencing in it, and in their turn reacting upon, and inducing disorder in, distant organs or in the general system.

These inter-reactions are exceedingly frequent. Indeed, it may be affirmed that no severe constitutional disorder can long continue in a woman during the predominance of the ovarian function without entailing disturbance in this function. And the converse is also true, that disorders of the sexual organs cannot long continue without entailing constitutional disorder, or injuriously affecting the condition of other organs.

These facts point to the necessity of guarding against the error of fixing our attention too specially upon one particular class of symptoms or upon one organ. Whilst searching out the part which is more especially the seat of diseased action, we must be careful not to overlook possible disease elsewhere, and not to neglect to observe the mutual reactions. The clinical physician, although led by the intuition of experience to seize quickly upon the offending part, will not omit to pass under review the state and working order of the other parts. In this manner most important complications are often brought most unexpectedly to light; and in every case some useful indication in treatment is discovered. The late Professor Chomel, a man of admirable skill, sagacity, and judgment, never failed, when a new case of disease came under his care, to interrogate successively every function. Thus, I have seen him in a case of pneumonia, the signs of which at once arrested attention, proceed nevertheless to explore the abdomen, the uterus, and the rectum. This may look like carrying out a principle to extremes. Yet who shall say that Chomel, as a clinical teacher or as a physician, was wrong?

It is not, indeed, necessary, in ordinary practice, to follow out in rigorous completeness the plan which to the clinical professor may seem desirable. It will therefore be useful to ascertain *what are the leading symptoms which, alone or grouped, indicate such disorder of the sexual organs as to call for direct exploration.*

This is the question we have set before us: When a woman presents herself, complaining of certain symptoms, chiefly subjective, some, or perhaps none, referred to the pelvis, how are we to act? Will these subjective symptoms enable us to refer them to their cause, to establish a diagnosis, to give satisfactory indications for treatment? Hardly. We must therefore call to our aid the objective signs; we must weigh and determine the significance of these before we can arrive at a conclusion at all precise or trustworthy as to the underlying pathological condition. The whole tendency of modern medicine is to subject every organ which manifests functional disorder to direct physical exploration, in order that it may solve the question presented obscurely by the subjective signs. The sound, the probe, the stethoscope, the laryngoscope, the otoscope, the ophthalmoscope, the various forms of speculum, are only so many contrivances for enabling us to project or extend the senses of touch, sight, and hearing into the internal structures. In the case of the skin, all is at once exposed to direct observation; and, as Alibert remarked, we should be glad to have the same advantage in investigating and treating the diseases of the heart, lungs, liver, kidneys, and nervous centres. Why is it that the study of the pathology of the skin and of the eye is invested with such fascinating interest? Those who devote themselves with the greatest zeal and success to this study will tell you that it is because the skin and the eye reveal their condition directly to the senses, and thus furnish not only positive objective signs which the patient can neither suppress nor misrepresent, but also because in this direct observation of the skin and eye they can read and follow as on a map or on a telegraphic dial the working of distant organs and of many affections of the general system. Here,

then, you see how the reputed special practitioner, turning to account his special experience, often acquires an insight into general pathology denied to those who neglect the lessons they might read upon the visible organs.

This advantage we possess to a great extent of perfection in the case of the pelvic organs. It is by the proper use of this advantage that so great a degree of precision in knowledge, and of success in treatment of diseases of women, has of late years been attained.

And there is one property in a high degree characteristic of the instruments employed in the investigation of the diseases of women of such singular value that it ought to completely silence the objections at one time so passionately urged against them. It is this: the instruments have a therapeutical as well as a diagnostic application; the speculum, for instance, revealing a lesion of the cervix uteri, enables the surgeon at once to apply his remedy. Thus treatment follows upon the track of diagnosis, one sitting and one operation serving for both.

Here, then, as in medicine generally, our first indication of the direction in which we have to look for the disease which causes the patient to complain, lies in the disturbance of function. We have then to consider what these functions are. The first in importance, because it is continued with occasional interruptions throughout the period of active sexual life, is *menstruation*. The other functions are incidental to married life only; these are *the relation to the other sex*, *pregnancy*, and *lactation*.

Most of the diseases which attack the ovaries and uterus, whether primary or secondary, entail some disturbance in the menstrual function. The flow is diminished or in excess, or its periodicity is deranged. It is attended with pain in the pelvic organs and other nervous phenomena.

We shall discuss the history of amenorrhœa, menorrhagia, and dysmenorrhœa hereafter. Our object now is simply to determine the conditions which suggest local examination. In the great majority of cases of *amenorrhœa* in single women, no local exploration is necessary: but in some cases it becomes imperative; for example, amenorrhœa is sometimes presumptive only—that is, the secretion takes place, but, owing to some imperfection of structure, it is retained in the cavity of the uterus or vagina. This may be called *occult menstruation*. The suffering becomes urgent in the highest degree, and nothing short of an operation which shall liberate the retained secretion will save the patient. Some cases, again, of suppressed menstruation, leading to effusion of blood behind the uterus, setting up circumscribed peritonitis, and displacing the uterus so as to press upon the bladder, may cause retention of urine. Here again local examination is imperative. This may be said of every case of retention of urine. In almost every case of retention of urine in women the cause is external to the bladder, and in the great majority it is due to some disease or displacement of the uterus.

Menorrhagia is a relative term; that is, some women lose much more than the average without suffering in health; but whenever the loss continues profuse, obviously entails anæmia and general debility, and persists in spite of internal remedies, local examination is clearly necessary. We shall often find a sufficient local cause in polypus, tumour, inflammation, congestion, hypertrophy, displacement, or malignant diseases, all of which conditions require local treatment.

When we come to study the history of *dysmenorrhœa* we shall find abundant proof of the almost constant association of this disorder with a mechanical condition of the uterus impeding the easy performance of the function. So long, however, as the distress does not clearly affect the general system, so long as it does not exceed endurable bounds, and if it appears to be moderated by general remedies, it is not necessary to examine; but, in the contrary event, examination should not be long postponed. To postpone examination is to postpone discovery of the cause and effective treatment. This is more especially imperative in the case of a married woman in whom dysmenorrhœa is complicated with dyspareunia and ste-

rility. Abortion, if not primarily depending upon some local disease or displacement of the uterus, is so very likely to be followed by some such condition, that an examination should be instituted. If a sanguineous discharge, even periodical, resembling menstruation, goes on during lactation, especially if it be excessive in quantity and attended by leucorrhœal discharge, it may be almost confidently predicated that there exists some uterine disorder requiring local treatment.

I have used a new word, "*Dyspareunia.*" It is incumbent upon every one who coins a new word to explain its meaning and to justify the innovation. Just as the word "dysmenorrhœa" has been coined in order to express compendiously the condition of difficult or painful menstruation, just as "dyspepsia" is used to signify difficult or painful digestion—we want a word to express the condition of difficult or painful performance of the sexual function. Such a word would be convenient in many ways. It would enable us to avoid the longer and coarser forms in use, by substituting a single word at once euphonious, expressive, and in harmony with medical language. After consulting with my colleague, Dr. W. H. Stone, whose high classical attainments give authority to his advice, I have determined to adopt the word "dyspareunia." It is derived from δυσπάρευνος, a word used in this sense by Sophocles. However disagreeable the topic may be, it is impossible to escape reference to a function so important. Dyspareunia in the female is perhaps the most absolute of all the indications of local malformation or disease. It calls the most imperatively for local examination as to its cause. In its milder forms it may make the sufferer's life a course of physical and mental wretchedness; in its severe forms it virtually unsexes her; and in any form it may lead to the most disastrous social calamities.

Taking this condition, dyspareunia, as a symptom of disordered function, we shall be astonished, when we proceed to direct examination of the organs concerned, at finding how many those causes may be, and what a wide field of pathological inquiry is associated with it. For example, there may be original defect or malformation; there may be obstructing tumours or growths, inflammation, dislocation or altered form, disordered innervation—in short, almost every disease to which the sexual organs are liable may entail dyspareunia for one of its consequences; and in not a few of these diseases disregard of this symptom may entail positive danger.

The existence of *certain discharges*, such as blood, under conditions of quantity and times of occurrence which distinguish it from normal menstruation, mucus, pus, albuminous, aqueous, fleshy, or membranous, if at all protracted, point clearly to some local disorder as their origin which requires direct exploration.

Then there are some subjective signs, as pain, lumbo-dorsal, iliac, pelvic, or crural, and a sense of bearing down or pressure upon the rectum or bladder, entailing disorder in the function of these organs. These, especially if connected with abnormal discharges and other symptoms, call distinctly for local investigation.

Then we must observe the constitutional or remote effects of the foregoing conditions. Disorder of the pelvic organs seldom goes on long without entailing anæmia, disordered digestion, hyperæsthesia, neuralgia, or other manifestations of nervous derangement or prostration. Where these conditions are observed in association with marked signs of derangement of function of the pelvic organs, the necessity for exploring the physical state of these is as clear as is that of examining the state of the heart or lungs when these organs perform their function with distress, and the whole system suffers.

Such, then, is a summary view of the conditions, chiefly subjective, which point out to us the desirableness of instituting direct observation of the pelvic organs. This direct observation commonly enables us to analyze the groups of subjective symptoms; to determine the cause and significance of each, separately and collectively. It always brings to our assistance the discovery of other symptoms,

entirely objective; and almost always puts it in our power to apply the proper treatment.—*Lancet*, Oct. 21, 1871.

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Abstract of a Clinical Lecture on the Diagnosis of Urethral and Vesical Diseases. By Sir Henry Thompson, Surgeon to University College Hospital. (Delivered Nov. 21, 1871.)

I commence to-day my usual course of lectures, modified somewhat by circumstances. Thus I desire to condense a little my opening remarks on diagnosis to-day. I may premise that I give this course of lectures on the diseases of the urinary organs because my wards offer you so large a field for their study, and also because there is no class of diseases in which you can afford so much relief to the patient as in this, or so certainly mitigate suffering. There are no diseases more painful, and none the relief of which will gain you more gratitude from your patients.

In the matter of diagnosis, however, it is of the greatest importance that it should be a correct one, and not only correct, but rapidly made. I have now to say what I have said to you before, that I interrogate all these patients on the same system, and I advise you to follow this plan. I employ only four questions for urinary patients, and I advise you to use these four questions also, and always in the same order. The first question is, Is there any deviation in the frequency of passing urine? The second is, Is there any pain in the act? The third is, Is there any blood in the urine? And the fourth is, Are the characters of the urine altered (quality and quantity)?

We shall see that in all cases of urinary diseases these four questions are sufficient, together with the supplementary inquiries which arise out of them; yet we know how often such cases are misunderstood—indeed, the simplest are often mistaken, through not pursuing a systematic method in arriving at a diagnosis. First of all, let us look at the question of *frequency*. Almost every disease of the urinary organs produces some deviation in the natural frequency of passing urine. As a rule, let it be understood that a man in health does not generally rise at night to pass urine, and that he passes it during the day about five or six times; but when there is any degree of inflammatory action in the mucous membrane of the bladder, however slight, frequency of micturition is induced. Now, how does cystitis produce this increased frequency? When the mucous coat of the bladder is inflamed, it cannot bear to be much extended; and when the bladder contains five or six ounces of urine, or even less, the sensitive mucous membrane suggests that it should be emptied; instead of comfortably containing fifteen or sixteen ounces, it cannot endure the extension, and calls on the muscles to contract without delay. There is one, and one only, of these affections which does not necessarily produce, at first, frequent micturition. I speak of stricture: here it always occurs after a time; but a man may have a considerable amount of stricture for years before he is troubled in the way referred to. Calculous disease produces cystitis, and thus causes an increased frequency in passing urine. Now, as a supplementary question, you should next ask, Is the frequency greatest at night or in the day? If a man have calculus in the bladder, he is not so much disturbed at night, but in the day he is frequently micturating—all movements make him do so. Now, that extremely common complaint *hypertrophy of the prostate* is worse at night than by day, as far as frequency of passing urine is concerned. Hence, if a man of about sixty years of age says that he has but recently had urinary troubles, and these are greatest by night, the case is almost made out; you may be sure that a very little further inquiry will demonstrate the fact that he is the subject of hypertrophied prostate.

I come to the second question, of *pain*. This question is of greater significance. Suppose the patient says he feels pain. Where do you feel pain—low down in the belly? Then there is almost certainly chronic cystitis. Suppose he says that his pain is in the penis or perinæum, you must ask if he feels the pain before, during, or after passing urine. If the pain be before, that is because the mucous membrane is

becoming uneasy in consequence of distension. If he find it painful during or after passing urine, and in the end of the penis, he is likely to have stone; and especially, also, if the pain be increased by exercise. The pain is at the end of the penis in stone. It is almost pathognomonic of calculus to find the pain near to the end of the penis during and after micturition. In chronic prostatitis, the pain is also at the end of the penis. This simulates calculus in the bladder more than any other disease.

The third question is, Has *blood* passed? This brings us nearer still to the point. Blood may be seen in cystitis, but very rarely. The mode and the circumstances in which the blood has passed, however, determine the nature of the disease. An elderly man, who passes blood intimately mixed with the urine, dark in colour, and not altered much by circumstances, with frequent rather than painful micturition, has probably hypertrophy of the prostate. In calculus of the bladder you find blood: it is as common in calculus as hæmoptysis is in phthisis. Then a calculous patient will find blood in the urine after a drive or a ride, or after hunting, and none if he keep quiet; or he may pass a drop or two with the last expulsive effort at micturition, and with pain at the time. Such urine is usually rather florid in tint, while, generally speaking, blood passed from the kidney remains long in the bladder, and, from contact with the urine, becomes brown in colour—it is like porter. This, also, may happen when the bleeding is due to hypertrophy of the prostate.

Lastly, Is the *character* of the urine perceptibly changed? A man will often tell you his urine is thick; but he does not discriminate between the thickness of pus or mucus, and that from deposited salts, as lithates. Patients are generally very much disturbed, unnecessarily, on account of thick urine. In this cold weather, the urine, on cooling, deposits its lithates readily, where none would be seen in summer; and you may tell him that, if he apply a little heat to it, he can see for himself that it will become quite clear again, which is never the case if the thickness be due to organic matters like pus or mucus; and if this be not an habitual appearance, you may make light of it. If, on the other hand, a heavy deposit of lithates be constant, you must look into his habits and correct his digestion—probably restrict some indulgence in diet. If, also, the urine do not become clear with heat, you have an organic compound to deal with, and you must find out carefully the source of it.

Let me advise you always to make your patient pass his urine into two vessels for examination. I should not thank you for an examination of urine passed into one vessel; for whatever a man may happen to have lying in the urethra—a passage which is by no means always clear and sound—passes with it. Let him pass an ounce or two into one vessel, and examine only what you find in the second vessel. If there be gleety discharge, if there be stricture of the urethra, you will find shreds of pus and mucus and blood-corpuscles in the first glass, but not in the second. In chronic prostatitis, always in hypertrophy of the prostate, sometimes there will be deposit in the first vessel, which would much mislead you if you imagined it to come from the bladder or kidney. This specimen you must examine for albumen, for sugar, and you must inquire also the quantity passed *per diem*. Well, then, if a patient have told you that he has frequency of passing urine, increased by exercise; that he has pain at the end of the penis; that he passes blood; and that his urine is changed—you may arrive at a pretty good diagnosis of his case. But you would be much to blame if you did not further examine the man: you must pass an instrument. It is best to be straightforward with patients and tell them so. People have too much common sense to be dealt with otherwise than plainly in these matters. You need not always sound a man with a stiff, rigid metallic instrument at first, who has never had an instrument of any kind in his urethra. It is best to take a soft instrument, pass it gently into the bladder, which produces very little discomfort, and so diminish the patient's fear. You can then say, pass another instrument (which will give you a little more pain), and

ascertain completely what is the matter. —*British Med. Journal*, Dec. 9, 1871.

HOSPITAL NOTES AND GLEANINGS.

Summary of Five Cases of Acute Rheumatism in St. Mary's Hospital, with Clinical Remarks on their Duration and Treatment. By Dr. HANDFIELD JONES.—The abatement of the symptoms of acute rheumatism is so gradual that it is difficult to date accurately the cessation of all morbid action; but in the following cases the subsidence of pain, and the decline of the temperature and pulse to the normal standard, have been taken as the guide. If any inaccuracy remains to be allowed for, it is that the duration of the disease has been overestimated rather than the reverse.

In the case of J. E—, aged forty-nine, whose attack lasted about forty-five days, alkalies were resorted to for two days, then quinia in full doses, and lastly strychnia. His urine remained alkaline for sixteen days or more after the alkali had been omitted. A. B——, aged thirty-three, recovered completely in eleven days. Full alkaline treatment was commenced on the fourth day, and gradually slackened. He took no other kind of medicine. In the case of C. G——, aged twenty, the disease lasted only nine days. The treatment commenced on the third day, and consisted exclusively of five-grain doses of quinia, four times a day. His urine was found to be alkaline on the fourth day. J. B——, aged twenty-seven, was admitted on the fifth day of illness, and remained subject to rheumatism about twenty-nine days. Five-grain doses of quinia, repeated four times a day for three days, produced no improvement. He was therefore ordered one grain of iodide of potassium and five grains of the bromide, in two ounces of citrate-of-potash mixture, every two hours. In four days he exhibited a decided improvement, and in a week he was comparatively well. The fifth case was that of a man of good constitution, thirty years of age, who was admitted on the fourth day of his illness. He had full alkaline treatment and none other, and recovered in thirteen days.

Dr. Handfield Jones's remarks on these cases were to the following effect: It is clear that acute rheumatism has not a fixed period of continuance, but is, on the contrary, subject to very considerable variations. The question then arises, on what conditions do these variations depend? To some extent, possibly, on the time which elapses before a case comes under treatment, but to a very much greater extent on the *quality* of the individual system. Some systems present a much greater resisting power to morbid agencies than others, succumb when they are overborne only for a short time, and then rapidly spring back again to health; others when once depressed are very slow to regain their former status. Advanced life and debility, however induced, favour the latter condition. Predisposition to a particular disease must also be taken into consideration: some are prone to gout, some to rheumatism, some to Bright's disease, and some to fatty degeneration; and whatever that predisposition may consist in, the man who is predisposed to rheumatism will succumb more readily to acute rheumatism, and recover more slowly than a man who is not. Therefore, as it is difficult in any given case to form a definite estimate of the strength of a man's constitution, or of his degree of debility, as well as of his predisposition to disease, it is a very difficult matter to determine beforehand the duration of an attack of rheumatic fever.

The next question is, what are the circumstances which should direct the physician in the choice of *remedies?* These also admit of only vague definition. In some measure they depend on the same circumstances which influence the duration of the disease. It is almost certain that as soon as the *urine* becomes alkaline (and it is so sometimes from the commencement), the use of alkalies will be not only useless, but injurious; still more certainly will it be so if the perspiration also be alkaline or neutral. If, on the contrary, the urine be highly acid and rather scanty, alkalies are very likely to be serviceable. When there is great thirst, with a dry, clammy mouth, alkalies in an effervescing form are very grateful. The state of the *pulse* is important. If it be very weak

and soft, alkalies are contraindicated; this is especially the case if, at the same time, the skin yield a copious flow of neutral sweat. In such cases quinia in full doses is very often of great service. Not unfrequently a mixed treatment of alternately given quinia and alkalies, as practised by Dr. Garrod, is productive of much good. In a recent case of a woman who was very weakly, anæmic, menorrhagic, much distressed, restless and half delirious at night, with a high temperature, that treatment was followed in four days by almost entire freedom from rheumatic pain, and by greatly improved sleep, although the temperature remained high for many days afterwards.

The condition of the *nervous system* should be noted. When it is irritable, bromide of potassium and repeated subcutaneous injection of opiates afford more relief than any other measure.

Blisters are allowed by Dr. Gull and Dr. Sutton as valuable agents in relieving suffering, though they do not curtail the course of the disease. But they are not suited to cases in which there is not much inflammatory swelling, although the pain and intolerance of movement be very great; they add to the nervous irritability, and may advantageously be made to give place to continuous poultices, medicated, perhaps, with laudanum or an alkaline solution.

Purgatives, containing calomel, or podophyllin, or extract of colchicum, should always be given at the outset, and repeated according to need if the tongue be foul, the taste perverted, and the patient loathe food.

For the *pains* which are apt to linger *about the shoulders and arms* after all febrile action has ceased, the subcutaneous injection of atropia will generally be found to be the best remedy, but sedative liniments are often useful.

As to *food*, the leading of the appetite should be followed. It can be of no use to intrude on an unwilling stomach food which it cannot digest; but as soon as the patient desires solids he should have them. Until then, soups and milk and such like food are essential.

A high temperature appears to be rather an indication for giving than withholding *stimulants*, and wine should always be given during the febrile stage if the patient be low.

In conclusion, Dr. Handfield Jones said that remedies administered carefully and with discrimination may, and often do, effect much good; and that, although the intimate pathology of acute rheumatism is so little understood that a rational treatment is impossible, no justification can be advanced for the neglect of treatment by drugs.—*Lancet*, Nov. 4, 1871.

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Case of Dislocation of the Left Hip; Reduction by Bigelow's Method.—G. B., a stout, muscular man, æt. 31, a surgeon, was admitted into University College Hospital under the care of Mr. Erichsen, Dec. 18th, with all the ordinary signs of a dislocation of the hip into the sciatic notch. The dislocation had occurred thirteen hours previously, and happened thus: The patient was leaving a railway carriage while the train was still moving, when he stumbled and fell down between the moving train and the side of the platform. He fell on his left side, with his head towards the engine. His left thigh was flexed, and his right extended. He thus got jammed between the carriage and the platform, with his left knee against the carriage and his back against the platform. His back remaining fixed against the platform, and his left thigh being forcibly flexed by the moving carriages, and the space between the carriage and the platform being insufficient, the head of the bone was forced out of the socket when the thigh reached flexion to about a right angle with the body. He saved himself from falling on the rails by clinging to the footboard of the carriage.

Reduction was easily effected. The patient, lying on his back, was placed on a mattress on the floor. He was then fully anæsthetized. Bigelow's directions for the reduction of this dislocation were then followed out exactly. Mr. Godlee, the house-surgeon, standing on the left side of the patient, first flexed the limb to a right angle with the body. He then placed his foot upon the pelvis, to steady it, and made moderately forcible traction

from the flexed knee. The bone went in at once with a loud snap. The whole operation did not last a minute. The force used was by no means great. The limb was then put on a long splint, and the patient put to bed.—*Lancet*, Jan. 6, 1872.

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Hydatid of the Lung.—This is so rare a disease in this country that most practitioners have never seen it. But it seems to be very common in Australia, if we may judge from an interesting paper on the subject by Dr. L. D. Bird, of Melbourne, read before the Medical Society of Victoria, and published in the March number of the *Australian Medical Journal*. The most common site of pulmonary hydatids is the base of the lung. If the cyst is small or of moderate size, it may occasion no symptoms, and remain unnoticed; when symptoms do occur, they are those of mechanical pressure or irritation. The physical signs vary according to the size and locality of the sac. Unless the tumour infringe on the chest-wall, the percussion-note is not altered, but respiration is harsh and puerile or defective. The rarity of visible venous engorgement is, in Dr. Bird's opinion, a feature which distinguishes the case from one of intrathoracic cancer. If the cyst has originated near the surface of the lung, and is large enough to press on the chest-wall, the limited dulness and other physical signs of fluid will be noticed. The case is to be differentiated from pleurisy, abscess, or phthisis by careful limitation of dulness, the situation of it, and the symptoms and general history of the case. The existence in the sputum of echinococci and portions of cyst would of course be verifying. But this evidence is not available in the early stages of the disease. Hydatids and phthisis often coexist, and it is not always possible to pronounce a positive diagnosis. Dr. Bird claims credit for Victorian surgeons of showing the propriety and harmlessness of tapping these cysts in the lung. In Dr. Bird's experience, the first tapping, followed by medicines calculated further to injure the vitality of the parasite, of which bromide or iodide of potassium and kameela are preferred, is so often successful that he has ceased to take notes of such cases. A discussion followed the reading of the paper. There seemed but one opinion as to the frequency of the disease in the colony, and it was generally attributed to the pollution of drinking-water by the excreta of dogs containing the ova of tænia.—*Lancet*, July 1, 1871.

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Case of Probable Partial Obliteration of the Aorta.—A mason came in 1866 into Prof. Skoda's ward at the General Hospital, Vienna, for some passing affection. In the course of his physical examination of him, Dr. Schrötter, Dr. Skoda's assistant, was led by certain peculiarities which he found, to the above diagnosis, in which Professor Skoda coincided. We were enabled, by the kindness of Dr. Schrötter, to see the man recently, and now give the points in the case as they exist at the present time.

The subject of the supposed malformation is a strong, healthy man of twenty-eight, who works hard all day at his trade, and is able to lift heavy stones, or go through any exertion without fatigue or the slightest distress. On stripping his chest, the first thing noticed was a tremendous heaving apex beat in the sixth intercostal space, two inches outside of the left nipple, evident equally to sight and touch. Percussion showed considerable extension of normal cardiac dulness toward the left. At the apex both sounds were healthy on auscultation. At the third right intercostal space could be heard a loud, rough, systolic murmur, while the second sound was sharp and clear. At the same spot a systolic thrill could be felt on palpation, and a slight heaving of the skin over the space could be seen on looking along the surface of the chest. There were no other auscultatory phenomena. On now examining the radial pulse, it was found to be full and strong, but very slow—only 48 per minute, and Dr. Schrötter said that it ranged normally from 44 to 50. The abdominal aorta could not be felt by deep pressure. In the femoral artery of both sides the pulse was very feeble, and distinctly retarded when compared with the radial.

No enlargement of the superior epigastric branches of either internal mammary artery, or of the epigastric artery itself, can be detected. In the left axilla can be distinctly felt a large pulsating vessel, running almost vertically from above downwards. This is probably an enlarged long thoracic artery. On the right side a similar enlargement does not exist. On the back, between the bases of the scapulæ and the vertebræ, more developed on the left than right side, are two bundles of enlarged vessels, which are evident to the eye, and can be felt pulsating. There can be little doubt that they are branches of the posterior scapular artery, carrying blood into the intercostals; other possible enlarged anastomoses, between branches of the subclavian and axillary arteries and the arteries in the lower part of the body, cannot be made out.

From what has been previously stated, it will be seen that we have evidence here: 1. Of hypertrophy of the left ventricle to a high degree, indicating an obstacle somewhere in the course of the aorta. 2. Of a diminished blood stream through the aorta and its branches, below the origin of the left subclavian; and of a retarded pulse, showing that the blood takes a perceptibly longer time to get into these vessels at each systole than into the subclavians. 3. Of a normal pulse in the subclavians, and also, it should be added, in the carotids; an indication that the obstacle, whatever it is, lies beyond their origins. 4. Of a compensatory enlargement of certain branches of the subclavian and axillary arteries communicating with arteries which supply the trunk. 5. Of absence of all signs of heart disease, dyspnœa, palpitations, &c., which probably would not be the case if it were the aortic valves which are diseased. 6. Of a *stationary* condition of things. The physical signs are the same now as in 1866.

Finally, it seems that no other diagnosis is possible than that of a partial obliteration of the aorta, somewhere beyond the origin of the left subclavian, probably in the descending part of the arch.

There is one point which is not easy to decide—*i. e.*, the meaning of the murmur in the third intercostal space. Professor Skoda considers that it indicates an enlarged internal mammary artery; but then, why are its abdominal branches and the inferior epigastric artery not enlarged? Dr. Schrötter looks upon it as due to an aneurismal dilatation of the aorta behind the point of contraction, such as would be most likely to follow in the presence of the existing ventricular hypertrophy.

It would be only speculation to consider what further enlarged anastomoses exist in this case. That the compensation is in some way or other made complete is proved by the fact that the man's feet and legs are never cold.—*Lancet*, July 1, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Atomized Turpentine-water in Chronic Bronchitis and Consumption.—Dr. S. Goodwin, of Victoria, Texas, writes us that he has lately been using turpentine-water, inhaled by means of an atomizer, with signal advantage, in cases of chronic bronchitis and consumption, where there was copious expectoration of either mucus or pus, with hemorrhage and violent cough. The turpentine-water is prepared from spirits of turpentine by magnesia in the same way that aromatic waters are commonly prepared by druggists.

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Cancer unsuccessfully treated by Cundurango.—Dr. C. H. Kleinschmidt records (*National Med. Journ.*, January, 1871) a case of scirrhus of the mamma of three years' duration, treated by fluid extract of cundurango, in doses of a drachm three times a day. "The so-called specific," he says, "instead of producing any improvement whatever, acted upon the stomach in a most deleterious manner, at first diminishing and afterwards entirely destroying the appetite.

"On the tenth day of the cundurango treatment nausea and vomiting ensued after each dose of the drug, and continued for some time after. Nothing could be

retained, not even ice. The drug," he thinks, "hastened the fatal termination."

The editors in a note report the following cases communicated to them since their last issue:—

Mrs. C., an aged lady residing in this city, who had been suffering from mammary cancer of long standing, was placed upon the treatment with cundurango. After a few doses of the decoction she commenced vomiting, and continued to vomit for four days, and died.

Mrs. F., who was also under treatment with the drug for a like cause, has also died. The particulars of the case we have not learned.

Mrs. A., who but recently died of an intercurrent disease, was also subjected to the same treatment for supposed mammary cancer, without any beneficial effect. The cundurango was suspended because of the nausea produced. The regular physicians in attendance subsequent to the cundurango treatment, doubt the existence of cancer.

Dr. Garnett says of his case: "I have not hesitated to give it a full and fair trial in the treatment of one of my own patients, unhappily affected with well-marked and unmistakable scirrhus of both mammæ. In this instance the patient has been kept under the administration of the remedy in the form of infusion and fluid extract for eight weeks, without its having produced any visible effect whatever upon the indurated glands, or otherwise influenced the progress of the disease."

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Tapeworm cured by Kameela.—Dr. S. R. Knight bears testimony (*Philadelphia Med. Times*, Jan. 1, 1872) to the efficacy of the kameela (*Rottlera*, U. S. Pharm.) in tapeworm in three cases. He gave it as follows: ℞. Kameelæ ʒss; syrup. symplicis fʒj. M. Dose, a tablespoonful.

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Hydrate of Chloral as a Rubefacient and Escharotic.—A correspondent of the *Scientific American* strongly recommends the hydrate of chloral as a rubefacient and escharotic. He says: "When applied, the burning is precisely like that produced by a cataplasm of strong mustard; but, at the same time, a sedative action is perceived, which somewhat neutralizes the smarting, while it does not prevent an excessive irritation of the skin. It does not blister, but the part the chloral has been applied to becomes exceedingly inflamed, and more or less swollen; and, according to the length of time of application, shows a merely reddened skin, or a suppuration of several weeks' duration.

"I give you my mode of application: Take a piece of fresh adhesive plaster, of the size wanted, and crush fine, on its surface, with an ivory spatula, enough of the crystals of the chloral to powder the piece of adhesive plaster quite evenly; use the edge of the spatula to take off the chloral where it is more than a mere dust in thickness, but distribute evenly, leaving one-third of an inch margin for adhesion; heat the back of the plaster for an instant only, and apply. Leave it on about half an hour as a rubefacient, six hours as an irritant. To produce suppuration, put the chloral on the plaster in large quantities, and leave on from twenty-four to thirty-six hours; on its withdrawal, apply a stimulating salve, and afterwards heal with cerate. For an escharotic effect, apply the chloral, thickly spread, and, after twelve hours, repeat the application, if necessary.

"It is surprisingly active as a suppurative, and for this reason it will not be prudent to apply it to any part of the surface of the abdominal cuticle, as, in one case under my inspection, having been left on too long, it occasioned a deep ulceration that was difficult to heal."

In this new mode of use, the chloral is truly invaluable; it is easily applied, cleanly, and perfectly reliable.—*Boston Journal of Chemistry*, Jan. 1872.

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An Annual Exhibition for the Philadelphia Meeting of the American Medical Association.—Drs. Edward Hartshorne and D. Murray Cheston, the Chairman and Secretary of the Committee of Arrangements of the American Medical Association, have issued a circular in which they state they have been authorized to invite attention to the project of an exhibition of objects interesting to the medical profession, to be held in Philadelphia during

the next session of the Association, on the 7th, 8th, 9th, and 10th of May next. This exhibition is designed to resemble the displays of a similar kind which are prominent features of the annual meetings of the British Medical Association.

The aim of the committee will be to form a collection of instruments, apparatus, specimens, preparations, models, drawings, plates, books, and all other proper objects that may be offered in good time for the purpose; and so to arrange it for exhibition as to bring it under the convenient observation of every delegate and professional visitor. They hope, in this manner, to give to the arrangements as much of a professional character as may be in their power. Their desire is to aid in advancing the practical interests of the Association, by affording an attractive addition to the ordinary routine of written and verbal communications and discussions.

The committee appeal for contributions of objects to be exhibited, to members of the medical profession, pharmacists and manufacturers of chemicals, to opticians, instrument-makers, publishers and booksellers, and to all others who are concerned in manufacturing or dealing in whatever tends to illustrate the study and practice of medicine and surgery and the associate sciences.

The general plan of arrangement, and amount of space to be allotted to the several departments and collections, will have to be decided by the end of March; and all the objects to be exhibited must be within reach of the committee by the second or third week of April next.

In order, therefore, to prevent confusion and disappointment, lists of objects offered for exhibition, and estimates of the amount of space desired for the purpose, will be required early.

Communications addressed to Wm. Pepper, M.D., 1215 Walnut Street, and F. F. Maury, M.D., 1218 Walnut Street, the sub-committee on the exhibition, will receive immediate attention.

No special reports or comparative statements need be looked for, nor will the committee be responsible for the merits or demerits of the several objects exhibited, although obliged to exercise control as to admission and location. Novelty, recentness, and practical character will necessarily have weight in determining precedence; but not at the expense of whatever may be deemed especially characteristic or interesting, whether old or new.

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Compliment to Dr. H. J. Bigelow.—Mr. Jonathan Hutchinson, Senior Surgeon to the London Hospital, in a lecture on *Dislocation of the Hip-joint* (*British Med. Journal*, Dec. 23d, 1871), pays the following well-merited compliment to our countryman, Dr. Bigelow:—

"Next, gentlemen, let me say that I regard the researches of Dr. Bigelow in respect to our subject as amongst the most valuable of recent additions to the science of surgery. His essay on the *Mechanism of Dislocation and Fracture of the Hip* I recommend to you most strongly, as an excellent example of experimental investigation applied to a subject concerning which but too many had been contented merely to guess and speculate. I will endeavour to state to you briefly some of the chief results of the Boston professor's work—for details, of course, I must refer you to his book."

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Library of the College of Physicians of Philadelphia.—We are pleased to state that this library continues to increase rapidly. The increase during the past year has been 577 volumes, of which 152 were to the Lewis library, and 425 to the general library. The whole number of volumes in the library is now over 15,500.

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Reunion of the Alumni of the Jefferson Medical College.—This Association proposes to hold a social reunion during the meeting of the American Medical Association in this city in May next. The alumni of the college are cordially invited to attend. Those who contemplate being present are requested to send their names and addresses to either of the undersigned secretaries: J. Ewing Mears, M.D., 222 S. Sixteenth St., R. J. Dunglison, M.D., 636 N. Eighteenth St., Philadelphia.

Mortality from Smallpox in Philadelphia.—The deaths from smallpox during the past four weeks were as follows:—

Week ending	Dec. 30, 1871,	. . .	223
"	" Jan. 6, 1872,	. . .	230
"	" " 13, "	. . .	216
"	" " 20, "	. . .	209

Philadelphia Hospital.—Dr. James Tyson has been elected curator to the Pathological Museum of this hospital to fill the vacancy caused by the resignation of Dr. Wm. Pepper.

FOREIGN INTELLIGENCE.

Croton-chloral.—Dr. Oscar Liebreich, to whom we owe that valuable agent, hydrate of chloral, has lately been engaged in investigating the physiological and therapeutical properties of a new organic compound called croton-chloral, which is formed by conducting chlorine gas into allylene. A peculiar action of this new substance in animals is, that at first a high degree of anæsthesia in the head is produced, while sensibility in the other parts of the body remains intact. The second stage is, that the spinal cord loses its function, and reflex excitability is everywhere extinguished. During that stage both pulse and respiration remain unchanged. The third stage, which is induced by large doses, is characterized by paralysis of the medulla oblongata, and death. Animals may, however, be kept alive by artificial respiration, because the function of the heart is not interfered with; while the ultimate effect of hydrate of chloral is to paralyze the heart. The first therapeutical experiments with the new compound were made in the University Clinique of Berlin. Complete anæsthesia of the fifth pair of cerebral nerves was produced in a child, reflex excitability in the other parts of the body continuing unchanged at the same time. Pulse and respiration remained exactly the same during the whole time of the narcosis. Further experiments in insane patients showed that we possess in croton-chloral a remedy by means of which the brain may be profoundly narcotized without any other functions being disturbed, while by chloral not only the brain, but the nervous system altogether, is rendered anæsthetic, and the heart's action is diminished, which must always constitute a source of danger. Croton-chloral, therefore, promises to produce all the good effects of hydrate of chloral, without any drawback being attached to its judicious use. Its apparently specific effects on the fifth pair of cerebral nerves make us indulge the hope that it may perhaps be found useful in that most intractable affection—true tic douloureux, or epileptiform neuralgia of the face. —*Med. Times and Gaz.*, Nov. 4, 1871.

Popliteal Aneurism cured by Flexion in three days.—The *Bulletin de l'Académie Royale de Médecine de Belgique* contains an account by Dr. Larondelle of the cure of a popliteal aneurism of the size of an orange. Dr. Larondelle adopted Mr. Ernest Hart's method of forced flexion of the leg upon the thigh. There was œdema of the foot and leg. The bandage employed was applied after the fashion recommended by Mr. Hart in his first paper in the *Medico-Chirurgical Transactions;* and the patient, as in his second published case, was allowed to walk about the room with the help of a crutch. The bandage was solidified by starch. The flexion seems to have been forced a little in excess. At the end of the second day, as the patient was complaining much of the pain, the bandage was removed. The pulsation was less. A second bandage was applied, and on the third day the tumour was found to be solidified. The cure thus effected was permanent; and the tumour, at the end of five months, was reduced to the dimensions of a small hard kernel.—*British Med. Journal*, Dec. 23, 1871.

Pure Carbolic Acid for Medicinal Use.—The best preparations of the acid of commerce are seldom free from a disagreeable odour, foreign to the pure article, which renders their use in dentistry or to the throat objectionable. Mr. Church gives the following method of depriving the article of its gas-like odour: One pound

of the best carbolic acid of commerce (the white crystallized acid) is poured into two gallons of cold distilled water, taking care not to permit the *whole* of the acid to enter into solution. With a good sample, if, after shaking repeatedly at intervals, between two and three ounces of the acid remain at the bottom of the vessel used, this will be a sufficient residue to hold and contain all the impurities; with bad samples, less water must be used, or more acid. The watery solution is to be siphoned off, and filtered, if necessary, through fine filter-paper till perfectly clear. It is then placed in a tall cylinder, and pure powdered common salt added, with constant agitation, till it no longer dissolves. On standing, the greater part of the carbolic acid will be found floating as a yellow oily layer on the top of the saline liquor, and merely requires to be removed to be ready for use. As it contains 5 per cent. or more of water, it does not generally crystallize, but it may be made to do so by distilling it from a little lime. The portion collected up to about 365° Fahr. has at ordinary temperatures scarcely any odour, save a faint one resembling that of geranium leaves; and advantage may be taken of this curious resemblance still further to mask the slight odour proper to absolutely pure carbolic acid, by the addition to it of four drops per fluidounce of the French oil of geranium. This addition has the advantage of liquefying the pure crystallized product. The pure acid may be dissolved in 230 parts of water, and used as a gargle; or in 25 parts of water for painting the throat, or in 50 parts for the carbolic spray. We are sure that the profession will thank Mr. Church for the introduction of such a simple method of depriving this invaluable agent of its disagreeable odour.—*British Med. Journal*, Oct. 21, 1871, from *Chemical News*.

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Disinfecting Power of Carbolic Acid.—The disinfecting power of carbolic acid seems yet to be dubious, and certainly not so great as to be relied upon. Dr. H. J. von Ankum inserted a paper in *Morandschrift voor Natuurwetenschappen* stating the following facts: Atmospheric air, to which are added the vapours emanating from carbolic acid, is unable to hinder the development of lower organisms in water with hay, in milk, and in urine. He put those substances under a glass bell, with an opening at the upper side, and surrounded by little cups filled with carbolic acid. All was placed in a ventilating closet, and the arrangement was such that the air that passed the above-named substances was mixed, if not saturated, with the vapours of carbolic acid. After the lapse of a little time, the development of lower organisms took place just as if the fluids had been exposed to the free air. Von Ankum made use of pure and impure carbolic acid, and only once he saw, in using the impure strong-smelling carbolic acid, the formation of those organisms was retarded, and did not take place in so many forms. He concludes, from his experiments, that no disinfecting action can be expected from the vapours of carbolic acid when they are mixed with the atmospheric air in such quantity that the respirations can take place in it without damage.—*Med. Times and Gaz.*, Dec. 16, 1871.

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Cundurango.—At a recent meeting of the Aerztlicher Verein in Vienna, Dr. Schroff stated that the result of experiments made there with the alleged specific for cancer—cundurango—had shown it to be quite worthless, as our English trials have already proved it to be. The Austrian government had purchased a quantity of this supposed remedy, at a high price, for the purpose of having its effects tested in the Rudolf Hospital.—*British Med. Journal*, Dec. 23, 1871.

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Vaccination with Glycerized Lymph.—Dr. Weiss has contributed some important statistics on this subject to the *Vierteljahrschr. für gerichtl. und öffentl. Medizin.* His observations were made during an outbreak of smallpox among the war-prisoners at Alt-Damm in December, 1870, and January and February, 1871. He first vaccinated three children with lymph mixed with glycerine, brought from Berlin. The lymph taken from these children

was mixed with glycerine; and, from January 16th to March 6th, he revaccinated with the diluted lymph 5801 men, the operation being successful in 1586 cases. All the subjects had been vaccinated in youth, many two or three times; and in 4023 there were distinct cicatrices. From November 21st to January 21st, among 2687 men, there were 72 cases of smallpox, with 7 deaths. After the revaccination, from January 25th to April 15th, among 8851 men, there were 195 cases, with 22 deaths; viz., among the successfully revaccinated, 6 cases, no deaths; among those in whom revaccination did not succeed, 25 cases, no deaths; among the unvaccinated, 164 cases, with 22 deaths. Dr. Weiss mixes the lymph from the arm with five parts of glycerine and the same quantity of distilled water. He says that, placed in bottles covered with bladder, it remains good for a long time.—*British Med. Journal*, Dec. 23, 1873.

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Smallpox and Vaccination in Hamburg.—Smallpox has been raging fearfully in Hamburg lately. The following are the official statistics with which we have been furnished. They indicate, as usual, the great extent to which vaccination, even when imperfect or partially worn out, protects from death and modifies the disease, in the cases where, from want of complete or recent vaccination, it has not afforded an entire immunity. The numbers are: vaccinated, recoveries 2954, deaths 347; unvaccinated, recoveries 10, deaths 700. —*British Med. Journal*, Dec. 23, 1871.

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Smallpox in Dublin.—It is stated, on a computation of cases that have come to the knowledge of the authorities, that seven hundred cases of smallpox existed in Dublin on Saturday last, December 16th. Owing to the difference of opinion as to revaccination which exists among the profession in Dublin, the public have not generally adopted this precaution. Very many infants have been found unvaccinated by the City Dispensary medical officers in houses, and even in rooms, and sometimes in the same beds, with persons suffering from the disease. The general rule in such cases has been to vaccinate all such unprotected children immediately; and this step has been generally followed by prevention or diminished severity of the disease.—*British Med. Journal*, Dec. 23, 1871.

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Cholera.—This disease has broken out at Medina, and between September 21 and October 4 (twelve days) 773 deaths took place; all the caravans from Medina to Mecca were consequently compelled to perform quarantine before being allowed to enter the latter city. Cholera is now, however, reported to be present in Mecca; and though Jeddah is yet free from the disease, all arrivals from that place are treated as if suspected of cholera. A cholera death is reported at St. Jean d'Acre in a passenger from Constantinople. Cases have also occurred at Samsoon (though not since November), at Galatz (which is stated to be in a bad sanitary state), at Amol, a place in the neighborhood of the Caspian Sea, and at Astrachan. —*British Med. Journal*, Dec. 23, 1871.

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Oxyhydric Light.—An interesting experiment is in progress (*Lancet*, Nov. 11, 1871) at the Crystal Palace, which is now lighted with the oxyhydric light. The advantages offered by this light are great steadiness, whiteness, and power. It is as superior to common gas-light as that is to a farthing dip. It is produced by effecting combustion by means of pure oxygen instead of by atmospheric air. The great novelty is the mode of preparing the oxygen—viz., by means of manganate of soda, which substance, when alternately heated in air and steam, acts as a carrier of oxygen. Hitherto, the bar to the practical applications of pure oxygen has been the expense of obtaining it; but the new process, which uses up no materials (only the coal necessary to heat the retort and to boil the water), has rendered pure oxygen a very cheap gas. Should the new light become general—and there is a fair chance of its becoming so—we may expect fewer weak eyes.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Hæmoptysis. Delivered at St. Thomas's Hospital, by THOMAS B. PEACOCK, M.D., &c., Senior Physician to the Hospital.

GENTLEMEN: There are few affections which the practitioner is more frequently called upon to treat, and none which offer greater difficulties in the selection of their treatment, or are more alarming to the patients and their friends, than hæmoptysis. I have therefore thought that a few remarks on the subject would be not without use and interest to you, and the more especially as we have, during the summer and recently, had cases in the wards which bear upon several of the points on which I propose to speak.

Under the term of hæmoptysis, however, I must be understood to refer to cases of hemorrhage proceeding from the substance of the lungs or bronchial mucous membrane, not to cases in which blood is poured into the tubes from the sac of an aortic aneurism.

Hæmoptysis, thus understood, may occur under the following different circumstances: 1st. When there is considerable vascular excitement or active inflammatory action, while the loss of blood, instead of being, as in ordinary cases of pneumonia, a mere tinge, is entirely disproportionate to the amount of inflammation which exists; 2dly. When it arises in connection with extreme congestion, temporary or permanent, of the lungs; 3dly. When it occurs without having been preceded by any decided exciting cause, or after the operation of only some slight cause, and in persons who, though they may be at the time in good or average health, are predisposed, either hereditarily or otherwise, to consumption; 4thly. When it arises in persons who are already the subjects of

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disease in the lungs to a more or less marked extent.

The symptoms of the disease, the course which it is likely to run, and, to a considerable extent, the treatment which it should receive, will vary in each of these different forms.

The first form of hæmoptysis is generally seen in persons who have been much exposed to cold or damp, or to the two combined. I have known it occur after bathing, and in persons who had sustained hardships during stormy weather at sea. In these cases the hæmoptysis is not generally profuse, but the blood which is expectorated is very viscid, probably from containing a large proportion of fibrin, and is mixed with the products of inflammation. The inflammatory action may affect chiefly the cells of the lungs or bronchial mucous membrane, but more frequently the whole substance is more or less involved. The hemorrhage which occurs in acute plastic bronchitis, on the separation of the exuded false membrane, affords another example of this form. I have not myself seen any case of the kind, but various instances are on record, and I may particularly refer to two cases mentioned by Sir Thomas Watson. In this form of hæmoptysis, in addition to the signs caused by the presence of blood in the lungs, there will also be the usual evidences of bronchitis or pneumonia, together with the furred tongue, the flushed face, the dry skin, and the increased temperature which attend these diseases.

The second form of the affection occurs in connection with mitral obstruction and regurgitation, and especially with the latter, and is usually combined with pulmonary apoplexy. The blood expectorated in these cases is generally dark-coloured and airless. It is not brought up in large quantities, and is usually combined with other secretions, such as are thrown out in cases of chronic bronchitis, bronchopneumonia, and œdema of the lungs. Blood also is expectorated under similar circumstances in cases of imperfect expansion of the lungs combined with deformity of the spine.

The third and fourth forms of the affection are those which are of most common occurrence. In the first of these the expectoration is often very profuse, and the blood at first brought up is very fluid and contains much air. Subsequently it is often coagulated, dark-coloured, and airless. The expectoration rarely occurs to a marked extent at first, but generally there is a little blood brought up, perhaps only a few drops or a teaspoonful of fluid blood, or a small coagulated mass; and this may be followed, after an interval of a few hours or a day or two, by a similar but larger expectoration, and that again perhaps by a very profuse hemorrhage, which takes place rapidly, so that the patient will expectorate the blood constantly for some minutes or hours. Generally an expectoration of this kind arises after some failure of health; the patient has been languid or feeble, and his appetite and digestion impaired, suffering from a little cough, with or without expectoration, and has been noticed by his friends to be falling away in bulk for some little time. Under these circumstances, the first expectoration may occur without having been preceded by any obvious exciting cause, or only after some slight exposure to cold. In other cases, the hemorrhage occurs in persons quite in good health, and then generally follows the operation of some decided exciting cause—playing at cricket, football, or rowing, or lifting heavy weights; or it takes place in persons of dissipated habits after a debauch. It is rare that an expectoration of blood occurs suddenly, and equally suddenly ceases. Generally after the bleeding has come on somewhat gradually in the way described, and has continued for hours, or a day or two, it ceases, either entirely or partially, and recurs again, though to a smaller extent, in some hours, or in two or three days, or a week; and generally in the interval, and after the final cessation, blood, evidently of old date, is expectorated. Should a copious hemorrhage of bright blood suddenly occur, and equally suddenly cease, it will most probably have proceeded from the sac of an aneurism which has formed a connection with the trachea or larger bronchial tubes. During the process of cessation the sputum generally

continues bloody for some days, either the whole mass being more or less deeply tinged, or the matters expectorated consisting partly of bloody sputum and partly of ordinary bronchitic or pneumonic expectoration, having a more or less dark colour. Very often the sputum, especially when the hemorrhage has been profuse, is very offensive to the smell. Occasionally, when there has been large loss of blood, after some time has elapsed, the patient will cough up a distinct moulded and partly decolorized coagulum, or, as it was termed by the older pathologists, a "bronchial polypus."

The results of stethoscopic examination vary in these cases. Supposing the lungs to have been previously free from disease during the active period of the hemorrhage somewhat small crepitation is heard, though the sound is less fine than that which indicates the first stage of pneumonia, and the resonance on percussion will be little, if at all, impaired. Supposing the hemorrhage to go on, and the blood not to be entirely expectorated, a portion of the lung, generally under one clavicle, becomes consolidated; the movement of the parietes is almost entirely abolished; there is entire dulness on percussion; and the respiratory sounds are almost absent, or there is decided bronchial respiration. This dull space may be very extensive, occupying, perhaps, the whole of one upper mammary region, and generally, but not invariably, around the margins of the dull space, crepitation of a more or less fine character is heard. Subsequently, as the blood is expectorated or absorbed, the air again enters into the consolidated portion, and sounds similar to the returning crepitation of pneumonia become audible. I have occasionally known the anterior portions of the chest to yield a peculiarly clear note on percussion—to become, indeed, quite tympanitic, while the chest movement is almost abolished, and the respiratory sounds are nearly inaudible. The explanation of this peculiar condition is, I think, to be found in the obstruction of the posterior part of the lungs by the extravasated blood gravitating to the back as the patient occupies the recumbent position, and so causing the air more fully to inflate the anterior portions, while the obstruction in the tubes prevents the escape of the air which has entered into the distended cells. When, after a time, the removal of the blood from the posterior part of the chest allows the air again to enter into these portions of the lung, the undue inflation of the other part ceases, and the respiratory movements and sounds return without the occurrence, perhaps, of any crepitation, or any other morbid sounds, being heard in the inflated portion of the lung. Of course, after an attack of this kind there is more or less constitutional disturbance, for not only is the respiratory process interfered with by the extravasated blood, but there is also a rent in the substance of the lung, which is necessarily followed by inflammatory action: hence, the pulse is quickened; the breathing rapid and short; there is a troublesome cough, often both severe and frequent; and the temperature is raised. As these attacks generally occur in persons of debilitated habit, they are attended by considerable prostration of strength, the fever has a tendency to assume the hectic type, characterized by a low temperature and great feeling of exhaustion in the morning, and by marked increase in heat and aggravation of all the symptoms at night.

It has been thought that hemorrhage of this kind is necessarily connected with some deposit in the chest, but I am well convinced that it is not always so. I have seen cases in which the hemorrhage has proved fatal, and no appearance of tubercle has been found in the lungs; and, judging from clinical experience, I should regard such an occurrence as not uncommon; certainly cases of hæmoptysis are not unfrequently met with in which the lungs, if not absolutely sound, do not present evidences of material disease.

The last form of hæmoptysis is also of very frequent occurrence. In this the hemorrhage is not generally profuse; often it only amounts to some streaks or specks in the sputum, or to the expectoration of a few masses of deeply tinged sputum or of blood; but it is generally

of this description, because the blood-vessels in the neighborhood of cavities in the lungs are ordinarily occluded by adherent coagula. Occasionally, however, a large expectoration of blood takes place where there is decided disease of the lungs. Thus, in some cases, in consequence of the formation of a small cavity in the neighbourhood of one of the large branches of the pulmonary artery, the coats of the vessel, being deprived of support, become expanded, and so a small aneurism is formed, which giving way allows a large escape of blood to take place. This, I believe, generally occurs in early and rapidly progressing phthisis. In other cases of advanced phthisis copious hemorrhage may also occur from a vessel, probably only of small size, giving way. The blood oozing from it gradually fills the cavities, and is then expectorated in large quantities, simulating the sudden outpouring of blood by a large vessel. In cases of this description the physical signs will differ from those in the second form, as, in addition to those which may result from the outpouring of blood, there will be evidence of more or less previous disease in the lungs.

The immediate sources of danger in cases of hæmoptysis are—first, shock or syncope from the sudden and rapid occurrence of profuse hemorrhage in a healthy person, or from the escape of smaller quantities of blood in a person previously in delicate health or the subject of disease; and, secondly, apnœa, from the accumulation of blood in the lungs which the patient is not able to expectorate. It is, however, rare that the quantity of blood discharged at one time is so great as to destroy life by the shock which it occasions, if the attack occur in a person previously healthy; but in those who are the subjects of disease and already much reduced, such a result may readily ensue. So also the engorgement of the lungs from inability to bring up the blood which is thrown out, and consequent death from apnœa, is more likely to occur in a person previously phthisical. Most generally, however, death is the result of a combination of these causes, aggravated by the alarm which the hemorrhage creates; and thus patients often die after comparatively small losses of blood, and in whom there has occurred but little bleeding into the lungs.

The more remote sources of danger are—first, gradual sinking from repeated small losses of blood; secondly, the development of low inflammation affecting the mucous membrane of the bronchi, or the substance of the lungs, and more generally both; and, thirdly, at a still more distant period, the supervention of phthisis. Of these the second is, perhaps, the most frequent cause of the fatal result. It often happens, in cases where the patient has sustained very large losses of blood but where the tendency to hemorrhage appears to have subsided, that after a few days have elapsed inflammatory symptoms supervene and rapidly carry off the patient. In all cases, as there is necessarily some injury to the texture of the lung, inflammatory action must, however, ensue to a greater or less extent, and often there is a more general congestion of the lung, probably due to chill and exposure.

The prognosis in any given case of phthisis must be founded on the following considerations: 1. On the amount of blood which has already been lost, the degree of prostration which it has occasioned, and the ability of the patient to sustain a further hemorrhage should it occur. 2. On the condition of the lung as affected by the hemorrhage which has occurred, and the facility with which the blood effused has been expectorated. 3. On the previous state of health of the patient, as rendering it probable that the lungs were before in a healthy state or more or less diseased. 4. On the family and personal history, as indicating the existence of a predisposition to phthisis, which may entail danger of the supervention of that disease, even though the hemorrhage has been very slight, and the lungs at the time of the attack were entirely free.

It is often very difficult, when the practitioner is called to a patient who is spitting blood, and with whose previous state he is unacquainted, to ascertain the con-

dition of the lungs before the occurrence. The engorgement of a portion—most generally the upper part—on one or both sides, may give rise to all the signs of consolidation, and may lead to the conclusion that the patient was labouring under serious disease before the occurrence of the hemorrhage; yet this conclusion may be incorrect. With the progress of the case the signs may wholly disappear, and the patient may entirely recover, with little or no evidence remaining of any disease of the lung. On the other hand, the peculiar inflation of the anterior part of the chest, consequent apparently on the engorgement of the posterior portions, may entirely cover the dulness on percussion, which would otherwise have been occasioned by a limited deposit of tubercle or other kind of consolidation. If, however, the loss of blood has been small, and the patient is but little reduced by it, a very cautious prognosis should always be given; for at any time, when least expected, a repetition of the hemorrhage may occur; and in cases where there is reason to believe that the lungs were sound previous to the attack, and where the predisposition to phthisis is but slight or altogether absent, that disease may, nevertheless, sooner or later occur. Of course, however, the immediate danger is greater in proportion to the extent of the hemorrhage and the degree of prostration, and the ultimate danger of the supervention of consumption or of the aggravation of any disease which exists is equally increased by these causes and by the existence of a decided predisposition to the disease. In no cases, however, does phthisis more surely and rapidly supervene than when repeated attacks of hemorrhage occur at short intervals, though the amount of blood lost in each attack may only be trivial.

It is evident that the treatment which should be adopted in cases of hæmoptysis must vary considerably according to the circumstances under which the discharge of blood occurs. In the first form of the affection, or that in which the hemorrhage occurs in connection with considerable vascular excitement or actual inflammatory action, the treatment must be chiefly directed to the relief of that condition: though it may be necessary to employ remedies calculated directly to arrest the bleeding in conjunction with such treatment, or after the excited action has subsided. In such cases, therefore, we must employ sedatives, together with remedies that reduce the condition of the blood, and promote elimination, especially by the skin and kidneys; and I believe, though I have not myself of late years adopted the practice, that general bleeding to a moderate extent would in cases of this kind be often beneficial.

In cases in which the blood is expectorated from the rupture of vessels very greatly distended in consequence of obstruction to the flow of blood through the lungs, in connection with mitral valvular disease or otherwise, the loss of blood is not generally so large as to be in itself very important, though the lungs are often still further embarrassed by the infiltration of the blood into their tissue. In these cases the attention must mainly be directed to relieve the condition upon which the disease is primarily dependent. We should chiefly employ eliminants, so as, by promoting the flow of the urine and the secretion from the alimentary mucous membrane, to lessen the amount of the circulating fluid and relieve the general congestion. It is questionable whether in some of these cases the greatest relief would not be obtained by bloodletting to a moderate amount. This I have two or three times tried, and certainly in one case with very striking benefit. Most generally, however, the indication is to be carried out by the use of purgatives and diuretics combined with medicines calculated to give tone to the muscular structure of the heart. It is in these cases that digitalis is often found eminently useful, acting as it does as a diuretic, and, if not too long continued, giving strength to the pulse, and reducing its frequency. On this subject what I have said elsewhere has been somewhat misunderstood. I cannot doubt that the first effect of the exhibition of digitalis is to quiet the action of the heart and arteries, but I feel well convinced that this effect

is only of temporary duration, and that, if the remedy be long continued, it exercises a generally depressing power, under which the pulse again rises. I believe digitalis to be eminently useful, partly by its sedative and partly by its diuretic action, especially in those cases in which, with mitral incompetency, there is dilatation and weakness of the left ventricle, giving rise to great irregularity in the action of the heart, and generally combined with dropsy.

In reference to the third and fourth forms of hæmoptysis, they are mainly to be met by sedative and astringent treatment.

In all cases it is of the greatest possible importance that entire rest and absence of all excitement should be enforced; and this whether the hemorrhage be only slight or more copious. It must be borne in mind in cases where for the first time a small hemorrhage occurs, that such often precedes the outpouring of a large amount of blood, and every precaution should therefore be taken. It is also desirable that these precautions should be continued for some time, as it is quite impossible to say when the hemorrhage may not recur. After copious hemorrhage it is better not to disturb the patient for the sake of obtaining a good examination of the chest; the information so gained may be very valuable as furnishing the basis of a correct prognosis, but it may be gained at too great a cost. I have seen the discharge of blood brought on by simply raising the patient so as to examine the chest, and a fatal result all but occasioned. For the immediate checking of the hemorrhage, the spray of tincture of perchloride of iron is often very useful; and the presence of the medical attendant, and his calmness and composure when the friends and attendants are in the greatest alarm, will often do much to encourage the patient, and to lessen the loss of blood which would otherwise be sustained.

The remedies to be applied must vary with the nature of the case. If the hemorrhage be only slight, and the patient previously in good health, mild astringents, with slight sedatives, such as the sulphuric acid and sulphate of magnesia, may be all that is needed; but, when the hæmoptysis is profuse, the more powerful sedative styptics must be had recourse to, as the acetate of lead or gallic acid, and especially combined with opium to quiet the nervous excitement. In cases, on the other hand, in which the patient is previously feeble or much reduced, the more stimulating astringents, as the oil of turpentine, must be employed. The food given must be mild and unstimulating, but nutritious, for few persons who suffer from hæmoptysis are really robust and capable of bearing much reduction. The food also is generally given cold or cool, and it is probably best to do so; but I am not satisfied that much benefit results from swallowing ice. It cannot, I think, exercise much constringing on the vessel which is bleeding in the lungs, and may cause gastrodynia or diarrhœa. Still less do I approve of the application of cold water or ice to the exterior of the chest. It seems improbable that such application can have much effect in checking the hemorrhage, while it may, by increasing internal congestion, promote it; and it must certainly, by chilling the patient, be liable to cause inflammation of the lungs, which, it has been before said, is very apt in all cases to arise after pulmonary hemorrhage, and not unfrequently occasions the fatal result.

Whatever be the course of treatment which it is thought right to adopt at the commencement of an attack of hæmoptysis, sooner or later it is generally necessary to have recourse to more stimulating and supporting measures. Thus, if the hemorrhage continue, in place of sedatives the stimulating and tonic styptics must be given in combination with more decided support and the diffusible stimulants. It is often difficult to decide when the time has arrived for this change to be made, and it may be necessary to adopt at first a somewhat tentative plan. Thus ammonia may be given, or brandy diluted with water, beef-tea, or thin arrowroot, in very small doses, not more than half a teaspoonful or a teaspoonful, may be administered If the pulse become quieter, there can be no doubt of the

propriety of continuing the treatment, the doses being exhibited at more or less frequent intervals according to the urgency of the symptoms and the effects produced. I have thus frequently seen hemorrhage checked which was previously but little influenced by the treatment adopted. In some cases, and especially where the hemorrhage takes place into the lungs, and the patient, from weakness or other cause, is incapable of expectorating the blood, stimulants must be given most freely, and form indeed the only chance for the life of the patient. Above all things in such cases the most entire quiet must be enforced. Great care is often needed in exhibiting aperients. I have known alarming and almost fatal sinking caused by their action. The bowels should be relieved, but it is safest to accomplish this by the use of enemata.

In cases of the fourth form of blood-spitting, when there is already extensive and advanced disease of the lungs, and the patient's strength is much reduced, the treatment must be cautiously adapted to the amount of the hemorrhage and the power of the patient. In some such cases the hemorrhage depends upon some temporary congestion from exposure to cold, and, if only to a slight extent, it may be very much left to itself, or even met by some mild eliminating treatment. When, however, the bleeding is at all profuse, powerful stimulating styptics must be given. The support and stimulus which the patient was previously taking must also be very cautiously reduced, or it may be necessary still to continue it, or even to increase the quantity. The most complete absence of excitement must be enjoined.

The after-treatment of cases of hemorrhage rather falls under the course to be adopted for the prevention of phthisis, and has been already alluded to on a former occasion; it is therefore not necessary to dwell upon it at present. I may, however, remark that the danger of the occurrence of subsequent disease of the lungs being superinduced is greater in proportion to the large extent of the loss of blood which has been sustained, the prostration which it has produced, and the evidence of previous disease of the lungs, or of predisposition to phthisis, hereditary or acquired. Great caution also is needed in carrying out the subsequent course of treatment and regimen, that the patient should not suddenly become plethoric, that all active exertion of body or excitement of mind should be avoided, and especially that he should be carefully protected against the influence of cold. It is always desirable, if the patient's circumstances allow of it, that he should spend the first winter following an attack of spitting of blood in a warm climate or warm situation; or, if he be not too weak and be a good sailor and not liable to suffer from sea-sickness, he should take a sea-voyage, so as to enjoy the invigorating effects of fresh air and change of scene, without fatigue or undue exertion. It is undesirable that he should travel much by land, lest he should so take cold or have a return of the hemorrhage; and this is especially to be avoided in countries where, in the event of any serious symptoms supervening, he would be incapable of obtaining adequate medical care and attention.—*Lancet*, Dec. 23, 1871.

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Abstract of a Clinical Lecture on Dropsy. By Charles Murchison, M.D., Joint Lecturer on Medicine at St. Thomas's Hospital Medical School, etc. (Delivered at St. Thomas's Hospital Nov. 2, 1871.)

After noticing the general nature of dropsy, and tracing it to the osmotic circulation constantly going on in the tissues of the body, and between the vascular system and the serous and mucous membranes, Dr. Murchison said that the causes of dropsy may be reduced to two heads—(1) excessive venous repletion, and (2) diminished exhalation in one part of the body, leading to compensatory exhalation in another. There are some other causes, he said, which you will find mentioned, and which may contribute to the existence of dropsy; one of these is an altered condition of the blood. No doubt this may assist in the production of dropsy, as in anæmia or hydræmia, when the blood passes more easily through the membranes than in the state of health; still,

in the dropsy of anæmia, you will find the heart at fault mainly; there is a deficiency in its propelling power. There is a general impression that, in renal disease, the dropsy is due to an altered state of the blood; but I shall give you some reasons for a different conclusion—that the dropsy from kidney disease is to be explained by the second general cause which I have mentioned. Some writers speak of dropsy as sometimes having a nervous origin; and cases of dropsy, associated with paraplegia, and even with hemiplegia, have been recorded by Dr. Laycock, of Edinburgh, in support of this view. But this cause of dropsy is certainly far from common. It is very important to remember the two main causes of dropsy, for the key to the whole treatment depends upon them.

Dr. Murchison then divided the forms of dropsy, from a clinical point of view, into three: 1. Partial dropsy, or dropsy limited to one part of the body throughout its course; 2. Dropsy which is first partial, but becomes general; and 3. Dropsy which is general from the first. The first form is due always to excessive venous repletion; and this over-distension of the small veins is the result of some mechanical impediment to the venous circulation. Dr. Murchison illustrated this by various examples, and called particular attention to the clinical characters of the dropsy due to obstructed portal circulation, viz.: the beginning of the dropsy in the abdomen; the dyspnœa following, but not preceding, the ascites; the tendency to hæmorrhoids, vomiting, and diarrhœa, or to hæmatemesis; enlarged spleen and varicose veins on the right side of the abdomen. In the second form of dropsy, the swelling begins in the feet and proceeds upwards; and this also is due to excessive venous repletion, from obstructed venous circulation. But here the obstruction is in the central organ of circulation —most frequently mitral disease, or fatty heart, or dilated right side of heart, consequent on chronic bronchitis and emphysema. In the third form of dropsy, the swelling invades all parts of the body at once; and this is due to diminished exhalation in one part, leading to compensatory exhalation in another. This dropsy is almost invariably renal. Albumen is present in the urine. How is it that disease of the kidneys produces dropsy? On this point you will find great difference of opinion among different writers. In some works this question is rather evaded than answered; but the general view is, that in consequence of disease of the kidney, the blood becomes poisoned, and, as the result of this altered condition, the liquor sanguinis exudes. For example, Dr. Owen Rees, in the Harveian Oration, a few years ago, made the remark that the retention in the blood of the urinary salts made the liquor sanguinis permeate the membranes with increased facility. But there is one very important objection to this view of the case—that, if it be correct, it is most remarkable that in the form of kidney-disease, in which of all others there is the greatest tendency to the retention of the urinary salts in the blood, there is little or no tendency to dropsy. I mean the contracted granular or gouty kidney, the peculiarity of which disease is, that the patients often die of uræmic coma and convulsions, with little or no dropsy. We must look, then, for some other cause of the dropsy. It is this: you get a diminished exhalation of water from the kidney; and hence dropsy is chiefly met with in those forms of kidney-disease in which the tubes are blocked up by diseased epithelium or inflammatory products (acute nephritis and fatty kidney).

Dr. Murchison then made some remarks on treatment. In the first place, one great object is to relieve venous repletion, which, in the case of portal dropsy, may be accomplished by purgatives, which cause a watery exhalation from the bowels. Another object is to remove obstructions to exhalation from the skin or kidneys by diaphoretics, warm baths, diluents, and diuretics. Thirdly, you must endeavour to stimulate compensatory exhalation from the skin and bowels. You will also find much good derived from tonics, such as iron.

Several cases in the hospital were commented upon as illustrating the above remarks, and the details were given of two cases now in the wards, viz., a case of ascites due to disease of the vessel, and a

very remarkable case of general dropsy, in which there was no evidence of disease either of the kidneys or of the heart.—*British Medical Journal*, Dec. 23, 1871.

HOSPITAL NOTES AND GLEANINGS.

Cleft Palate.—In this case, admitted into King's College Hospital, there was a fissure of the whole of the soft and two-thirds of the hard palate in a young person. Sir W. Fergusson performed the operation upon the soft palate in the manner which he himself first proposed, dividing the muscles of the soft palate previous to paring the edges of the cleft. Chloroform was administered, and a new form of gag used, which consisted of two grooved plates to fit the teeth of the upper and lower jaws, connected by a horseshoe-shaped spring; this being placed on the teeth of one side of the mouth, was quite out of the way of the operator during his manipulations. Four sutures were employed to bring the edges of the soft palate accurately into apposition. The sutures were passed in the ordinary way; but an excellent plan is adopted by Sir W. Fergusson, who, to facilitate the adjustment of the sutures, uses them of two different colours, passing sutures of the same colour on the same side of the cleft, so that one colour indicates those to be withdrawn and the other those to be retained. In his remarks, after the operation, he referred to the use of chloroform in these operations, and said that the danger of giving much was owing to the loss of sensitiveness of the upper part of the larynx, and the consequent trickling of blood down the trachea and bronchi without corresponding reflex attempts to prevent it. The fact that even after the administration of chloroform some irritation was produced in the larynx and about the palate by the blood, was the cause of the restlessness shown by the patient, but this diminished during the later stage of the operation, when the parts became more tolerant of the cause of excitement in them.—*Med. Times and Gaz.*, Feb. 10, 1872.

Abscess within or around the Sheath of Brachial Plexus, simulating Medullary Tumour; Pus evacuated; Recovery.—J. S., aged 36, a printer's pressman, had suffered for some months from severe gnawing or stabbing pains extending from the shoulder down the inner side of right arm and forearm to the tips of the fingers. He had been treated at other public institutions for rheumatism. He was admitted under the care of Dr. WAITE, who, after inquiry into the antecedent history and occupation of the patient, found that the pain he complained of was deep-seated, and most severe about the neighbourhood of the axilla and supra-clavicular region. The elbow- and shoulder-joints were also at times very painful, which, associated with some pyrexia, probably induced the belief that the patient was suffering from subacute rheumatism. While under Dr. Waite's care, he was treated with bicarbonate of potash, iodide of potassium, and opiates; but the most powerful local and general sedatives failed to procure relief from the severe pains in the course of the nerves. He had little rest day or night—in fact, the nocturnal exacerbations were most severe. Dr. Waite attended him at his own home, and in a week or two after the application of large poultices to the shoulder the pain became somewhat less severe. On tracing up with the finger the course of the ulnar nerve to the apex of the axilla, a firm, hard, deep-seated, circumscribed swelling could be felt, as also in the supra- and post-clavicular regions. The natural inference was that a tumour of rapid growth, implicating and pressing upon the nerves of the brachial plexus, was the cause of the deep-seated pain and pyrexia. Mr. Churchill met Dr. Waite in consultation, and, after careful examination, was unable to obtain any evidence of fluctuation. The rapid growth, the febrility, and the decided increase of pain at night led to the suspicion of inflammatory mischief, although unaccompanied by local increase of heat or tenderness. The tumour was punctured with a large trocar and canula, and about two ounces of pus evacuated. The patient was instantly relieved, but the stabbing pains continued very severe. It was evident that pus was reaccumulating in the sac of the abscess, and about a week later Mr. Churchill made

a more extended incision, and gave free vent to the pus. The scalene muscles near their attachment to the transverse processes of the central cervical vertebræ were included in the abscess, which was now somewhat diffuse. The abscess healed from the bottom in the course of a few weeks, and his health rapidly improved. He was dismissed cured two months later. —*Ibid.*

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Shifting and Recurring Partial Hemiplegia in a Patient suffering from Bright's Disease. —The following remarkable symptoms are supposed by Dr. Nicol, under whose care the patient was, and by his colleague Dr. Bourne, to have been due to a shifting œdema about the pons Varolii.

J. W., aged thirty, suffering from Bright's disease, was admitted into the Bradford Infirmary, with extensive anasarca. His urine yielded more than half its bulk of albumen. After a course of hot-air baths, purgatives, and ferruginous tonics, the anasarca almost entirely disappeared, and the patient was enabled to get about. While in this condition, fifteen days after admission, he had, at midnight, an epileptiform seizure, which terminated in left facial and arm paralysis. He could not speak, but seemed to understand what was said to him. Mustard poultices were applied to the calves, and a catheter had to be passed.

On the following morning he was recovering slowly, and appeared to recollect all that had happened during the night. He spoke with difficulty. He was observed to be unable to close his eyes by a voluntary effort, although the usual winking took place. There were symptoms of lung congestion, for which poultices were applied. In the right axilla the temperature was 97·5°; in the left, 97°. In the evening the patient's general condition had much improved. On the right side the temperature was 97·4°; on the left, 99°. At ten o'clock in the evening another seizure occurred. This time the face was paralyzed on the right side; the eyes were drawn to the left; the power of speech was lost, he seemed unconscious, and yawned frequently. He passed urine in the usual quantity.

By ten o'clock on the following morning he was better, and pronounced simple words with difficulty. The face was not drawn, but the eyes were closed only with an effort. A grain of elaterium with four grains of calomel were placed on the tongue, and an enema of turpentine and castor oil was injected into the bowel. At ten in the evening a copious stool was passed, and in a quarter of an hour more the power of speech returned. It was found that though in the morning he had been unable to swallow, and could not protrude the tongue beyond the teeth, he had taken his dinner well. The bowels were still further freely opened.

The next day, the fourth after the first seizure, urine was passed in usual quantities, and he seemed to be quite well. He was ordered five grains of tannin three times a day, with milk and sherry. He remembered those who had been present during his last attack (several persons being present), and affirmed that he had been conscious of all that passed.

A third seizure followed at half-past one o'clock in the afternoon, after he had partaken fairly of dinner, and ended in right facial and arm paralysis, and partial loss of speech. Extensive dry cupping was practised for an hour; then an enema similar to the last was injected; a copious stool followed in rather more than an hour. The paralytic symptoms rapidly disappeared, and on the same day he was able to sit up in a chair.

On the following (fifth) day he was sitting up dressed; he spoke well, but the right arm was weak. He was ordered four ounces of sherry daily, and continued to take the tannin.

On the sixth day the urine was found to be acid, of a specific gravity of 1.010, and to contain pus-corpuscles to faint milkiness. It yielded rather less than one-half its bulk of albumen. Three days later the patient continued well, and the right arm was steadily gaining power. —*Lancet*, Sept. 16, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Mortality from Smallpox in Philadelphia.

Week ending	Jan. 27,	. . . . .	177
"	" Feb. 3,	. . . . .	158
"	" " 10,	. . . . .	183
"	" " 17,	. . . . .	136
"	" " 24,	. . . . .	138

It will be perceived by the above that the epidemic of smallpox is abating in Philadelphia. It reached its height in the week ending Dec. 2, when the mortality was 233, since then, with slight variations, it has been gradually decreasing.

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The American Medical Association will hold its 23d Annual Session, at Horticultural Hall, Broad St., Philadelphia, commencing at 11 o'clock A.M., May 7, 1872.

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New York State Inebriate Asylum, Binghamton, N. Y.—The reports of this useful institution for 1871 show it to be in a very satisfactory condition. The number of patients treated during the year was 315, of whom 184 were discharged with great hopes of permanent reformation; 46 were discharged improved, and the present number of patients is 85.

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Geneva Medical College.—The commencement exercises of this college were held Jan. 23d at Linden Hall. The degree of M.D. was conferred upon twelve candidates. With these exercises this institution ceases to exist.

A majority of the faculty have accepted chairs in the "College of Physicians and Sugeons of the Syracuse University." This institution will open for the reception of students some time during the current year.

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Rush Medical College, Chicago.—At the commencement, held on the 17th Jan. last, the degree of M. D. was conferred on 77 candidates.

The annual spring course for 1872 of this school will begin Wednesday, March 6th, and will continue to June 26th.

The Rush Medical College building having been destroyed by the great fire, the faculty, in order fully to maintain the interests of the college and to preserve its advantages to students of medicine, have secured the lecture and clinic rooms of the Cook County Hospital, cor. Eighteenth and Arnold Streets, in which to hold the usual spring course. Having tested the convenience of these rooms during a large portion of the winter term, they feel assured that the instruction will be as thorough and satisfactory as heretofore; and, therefore, confidently recommend that students of every grade avail themselves of their advantages.

As a means of acquiring practical knowledge, the spring course, it is claimed, offers superior inducements; the classes being comparatively small, and immediate personal inspection can be made of all experiments, operations, and demonstrations illustrating the several branches taught.

For further information address the Secretary of the Spring Course, Curtis T. Fenn, M.D., 1155 Michigan Avenue.

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Hamilton on Fractures and Dislocations.—The fourth edition of this work is most favorably reviewed in a very recent number of the *Med. Times and Gaz.* (January 27, 1872). The reviewer concludes with the following remarks:—

"In fine, the book is full of useful detail, is simple in its arrangement, explicit in description, and pleasantly and lucidly written. Its comprehensiveness and trustworthiness, and the facility with which reference can be made to any portion of its contents, make it a safe and valuable work to recommend as well to every practical man as to every earnest student.

"We cannot too thoroughly recognize the merits of the author, who has done so much to justify the fair name obtained by American surgeons."

—

Posthumous Work by the late Prof. Ronley Dunglison.—Messrs. Lindsay and Blakiston will publish shortly "A History of Medicine from the Earliest Ages to the Commencement of the Nineteenth Century." This work comprises the lectures delivered by the author when he was Professor of Medicine in the Univer-

sity of Virginia, carefully revised for publication by his son Richard J. Dunglison, M.D., so as to present the facts in book form.

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Editors and Publishers.—It is stated, in an editorial in the number of the *National Medical Journal* for February last, that, the proprietors and publishers of that periodical "having claimed the right to publish matter which the editors did not approve," the latter had withdrawn their connection with that journal.

Drs. Busey and Lee seem to us to have acted rightly in this matter, and to have taken a proper view of the reciprocal duties of editors and publishers. They could not, as honourable men, holding the responsible position of editors, allow the interests of science to be sacrificed to the private interests of the publishers.

The following is the very remarkable statement of the latter (the italics are our own):—

"The cause of the rupture is to be told in a few words. During the month of December an article was handed in, written by a friend and one of our *advertising patrons*, reflecting on a new preparation, introduced by another patron—called "Borobalsamine." The undersigned asked the editors to withdraw it, as it would *materially affect their interests* outside of the journal; but they declined, and promised that the reply of Professor Oldberg should also be published. Upon the presentation of the reply to the editors, they refused the article admission, and thereby materially injured the publishers in their *business interests.*"

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New Medical Journal.—Drs. S. C. Busey and Wm. Lee announce that they will commence, early in March, 1872, the publication of a monthly medical journal, under the title of the *Washington Medical Monthly*. Drs. Busey and Lee will carry into their new enterprise, we are sure, the sympathy and encouragement of their former contributors and subscribers, and we hope they will reap a rich reward from their manly efforts to maintain the honour and independence of medical journalism.

Medical Diagnosis.—Dr. William Pepper will give a course of practical instruction on this subject in the wards of the Philadelphia Hospital, extending from March 20 to June 20. The course will be entirely clinical, and each student will have ample opportunities of familiarizing himself especially with all the branches of Physical Diagnosis.

FOREIGN INTELLIGENCE.

Subcutaneous Injection of Morphia in Cholera.—Dr. John Patterson, Physician to the British Seaman's Hospital, Constantinople, speaks (*Med. Times and Gaz.*, Jan. 27, 1872) very favourably of this mode of treatment. He says: "I do not of course maintain that this treatment is a specific against cholera; I only claim for it that its action is more decided than any other treatment I have seen or practised, and that in the race against death we gain time for further treatment when it is necessary. It is long since I lost hope of the ordinary treatment influencing much the course of the disease, and, after treating more than a thousand cases at various times of epidemic, I am glad to report that this has really been of great service. My colleague, Dr. Werry, speaks equally favourably of the results obtained in his practice."

He gives the following table of his main results:—

	Number of Cases.	Recovered.	Dead.
Treated in the usual manner	10	1	9
Treated by morphia injections	42	22	20
Total .	52	23	29

But, of the cases treated by injection, 8 were perfectly helpless from the first, being *in articulo mortis*, 1 had severe liver complaint, and 1 was far advanced in consumption; so that, in reality, we had 32 cases where the treatment had a fair chance, reducing the mortality to 10 in 32; and of these 10, 1 was 60 years of age, 1 within a few days of her confinement, and 3 hard drinkers.

Xylol.—This hydrocarbon, it seems, has been used in Berlin in the treatment of smallpox with good results.

The *Berlin Klinische Wochenschrift* states that Dr. Zuelzer, of the Charité Hospital, had administered xylol in cases of smallpox, with the most complete success. It is given in doses of from 3 to 5 drops for children, 10 to 15 drops for adults, every hour to every three hours: as much as a teaspoonful at a time has been taken. The most convenient form of taking it is in capsules containing 3, 5, 8, and 12 drops each.

The theory has been broached that xylol is taken up by the blood, and acts as a disinfectant. Absolute purity of the xylol is necessary, as toluol and other analogous compounds do not possess this peculiar action, and it seems there are some practical difficulties in obtaining xylol absolutely pure.

Xylol, or xylene, C_8H_{10}, was first separated from coal naphtha by Dr. Hugo Müller; it is obtained by fractional distillation until a distillate is obtained of about 140° C. boiling-point; this is mixed with sulphuric acid, which dissolves xylol, forming xylol sulphuric acid; this acid is decomposed by dry distillation, and the xylol thus obtained is further purified. Pure xylol is colourless, it has a faint odour, somewhat like benzol, but different, boiling-point 139° C., sp. gr. 806.—*Med. Press and Circular*, Feb. 7, 1872.

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Detachment of the Periosteum in Gunshot Wounds.—M. Desprès, reporting on some cases of gunshot wounds to the Society of Surgery, called attention to the great detachment of periosteum at a distance from the fracture which sometimes takes place, and which he attributes to the concussive action of the ball on the bone, but which others refer to the effusion of blood near the seat of fracture. However this may be, extensive consecutive necroses take place, which may be followed by extensive reproduction of bone. Such detachment easily and almost completely takes place in spite of there being a great number of splinters, and constitutes an additional reason in favour of the precept of never amputating for a comminutive fracture of the leg or arm, however numerous the fragments may be, providing the arteries and nerves are not seriously damaged.—*Med. Times and Gaz.*, Feb. 3, 1872.

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Extracts of Meat from a Physiological Point of View.—P. Müller contributes an important article on this subject—important not only from the valuable *résumé* given of all that is known relative to the chemical composition of meat extracts, soups, etc., but as adding to our knowledge of the physiological effects of such extracts. The paper is divided into three chapters, the first of which treats of the fluid of muscles, soups, and extracts, stating the relative proportions of the several ingredients entering into these, and detailing the researches of Liebig and others in this field. Extracts of meat are shown to be destitute, or nearly so, of true alimentary substances (albuminoids), and to be rich in such nitrogenous substances as are incapable of acting as food. The second chapter deals with certain principles of organic origin, such as creatine, found in meat extracts; and these principles are stated from the accordant experiments of the author and Kimmerich (*Wein. Med. Wochenschrift*, 1869) not to be dynaphorics, like tea, coffee, etc. Further, the ash of extracts of meat is shown to exert a poisonous action upon animals. The concluding chapter treats of the action of potash salts upon the animal economy.

The following are M. Müller's conclusions:—

"1. Meat extracts are neither direct aliments, for they contain no albuminous matters, nor indirect aliments, for their azotised principles do not arrest disassimilation.

"2. In small quantities they may be useful, from the stimulant action of the potash salts which they contain, as these salts aid digestion and circulation.

"3. In larger doses, instead of being useful, they may have an injurious effect. Administered in the course of prolonged illnesses, when the powers are enfeebled by long abstinence, the salts of potash may exert an injurious action, more manifest in proportion to the quantity of chloride of sodium lost by the organism. Far

from favouring nutrition, they may impede it—(1) by the direct action of potash salts upon the blood globules, causing a diminished absorption of oxygen; (2) by the predominance of salts in the serum, which exert no special solvent action on carbonic acid, and do not permit the exhalation of the normal quantity of this gas, and, consequently, the introduction of oxygen.

"4. The physician should always remember that to give these extracts alone is to keep the patient in a state of inanition."—*Med. Times and Gaz.*, January 27, 1872, from *Moniteur Scientifique.*

—

Effects of Alcohol on the System.—Dr. Wilks, of Guy's Hospital, for the purpose of watching more closely the effects of alcohol on the system, has for many years prescribed a medicine which he calls "mistura alcoholica," composed of rectified spirit, tincture of cardamom, and water, to be given at intervals during the day. But it is only in a particular class of cases that it is applicable. For the various ordinary acute and chronic disorders he has used wine and brandy when he has considered them necessary. It has been more especially in cases of atrophy in children and in tuberculosis that he has used this form with the most beneficial results. He believes that he was indebted many years ago to Dr. Sutton (now of the London Hospital) for this method of administering alcohol, and he has continued to use it ever since with very often marked success. When physician to the Royal Infirmary for Children, Dr. Wilks often prescribed small doses of rectified spirit, according to the above formula; but, unfortunately, there is no record of the results. He remembers one case, of a little boy who was said to have marasmus. He lay in bed almost a skeleton, and had taken all kinds of nourishment, with cod-liver oil, in vain. He was then ordered small doses of alcohol four times a day, and rapidly improved, so that in a few weeks he was fat and strong.

Dr. Wilks says he must leave it to the physiologist to determine the action of alcohol in the system; but from the fact of its not being eliminated, and from persons growing fat who partake of it, he has never discarded Liebig's views; certain it is that wasted children often directly improve under its use.

At the present time there is a little boy, aged five years and a half, in Guy's Hospital, under Dr. Wilks's care, who is on this plan. He was admitted in an extreme state of emaciation on Oct. 25th. No disease could be found in him, and he was handed over to the sister of the ward to take charge of, as it was thought his ailments might be due merely to starvation. In spite, however, of good living, with a little wine, he did not improve, and therefore, after being in for about six weeks, on Dec. 15th he was ordered one drachm of rectified spirit four times a day. In a few days he was better. He was soon able to leave his bed, and he has been growing fatter and stronger ever since.—*Lancet*, Jan. 27, 1872.

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Diagnosis of Syphilis by the Microscope.—At a late meeting of the Vienna Medical Society, Dr. Lostorfer read a paper containing the results of investigations into the nature of the microscopic appearance of the blood of syphilitic patients. The researches have been continued several months in Professor Stricker's laboratory, and, as will be seen, confirmed by no less an authority than that of Hebra, and if further confirmed they will, beyond any doubt, be one of the most important discoveries for practical medicine.

During the last few years several attempts have been made at explaining different diseases, and particularly infectious ones, by the presence of fungous growths in the blood, secretions and excretions, as well as in the tissues of the human and animal body. In syphilis it was particularly the patients' blood which has been searched for organisms of a lower range. The results of these investigations, however, have been negative, with the single exception of Hallier, who describes a fungus, found in different infectious diseases, of that nature which has been called "micrococcus" by the same author. The micrococcus *per se* is not characteristic of any disease, but becomes so—according to Hallier's opinion—in the species produced by artificial cultivation. One of the greatest micrologists (De Bary) has

objected in a most emphatic manner to Hallier's method of cultivation—so that it has been abandoned by almost all workers in that direction.

Dr. Lostorfer thinks that the negative results of blood investigation have been due to two causes, namely—1. Hitherto nearly all researches have been made with too low powers; he is convinced that such investigations cannot be made with a less magnifying power than with Hartnack's eyepiece No. 3, and the immersion-lens No. 10. 2. All researches have been made with fresh blood, and the objects soon spoiled by an unfavourable method of preservation. The opinion has, unfortunately, always been prevalent, that what is to be seen in blood must be seen best in fresh blood, but it has been overlooked that things may be so minute as not to be viewed at first, but that they may grow to a visible size.

Under these considerations, Dr. Lostorfer commenced his researches in August, 1871, in Prof. Zeissl's wards for syphilis. The method observed was excessively simple. A small drop of blood, taken from a syphilitic patient, was put as quickly as possible on a clean object-glass, covered, the whole object conveyed to an exsiccatorium, arranged in a kind of Recklinghausen's moist camera, and daily carefully examined with the magnifying powers mentioned above. The result of the first four objects was already positive, and remained so afterwards in large numbers of objects, the blood having been taken from different patients suffering from various, yet unmistakable, forms of syphilis.

During the first two days of investigation nothing could be seen except vibriones, bacteria, and commencing forms of sarcina. In the third or fourth day, however, and, in exceptional cases, after the lapse of twenty-four hours, minute bright corpuscles became visible, some of which remained immovable, whilst others continued in a state of undulation. Some of these bodies exhibited a projection. On the fourth day (exceptionally on the third, fifth, or sixth day) the corpuscles were enlarged in bulk and in numbers. Of those enlarged, the majority had the projections just named, which were undoubtedly a kind of sprouts, which in some cases were larger in size than the corpuscle itself. In the following days the growing continued, so that some of these bodies became as big as, and even bigger than, red blood-corpuscles. Besides these, there were numbers of smaller corpuscles visible, growing and sprouting, some exhibiting one projection, others three or more projections; the latter were sessile, or had a minute pedicle. The corpuscles were by no means all globular, but of different irregular shapes. After eight or ten days a vacuola was formed in the larger corpuscles, which extended over the whole corpuscle, and terminated the further development of the growth. Different fluids, as sugar, Pasteur's liquid, common salt, acetic acid, etc., were not able to arrest the shrivelling of the bodies and further retrograde development.

Concerning the number of corpuscles, it varies greatly in different cases. Whether this be dependent upon the different stage of the disease, cannot yet be said, and must be reserved for further investigation. Dr. Lostorfer has treated in a similar manner the blood of patients labouring under gonorrhœa, diphtheria, eczema, typhus, elephantiasis, and lupus, but never found anything to be compared with the appearance of syphilitic blood. Dr. Lostorfer is cautious enough not to give any opinion as to the relation of the "syphilis-corpuscles," as he calls them, to the disease; whether they be the cause or the result of the latter he pretends not to know, but contents himself to state the facts he has found. After having alluded to a number of patients (and their histories) from whom he had procured blood for examination, he winds up with the statement that he is able in any case to form the diagnosis of syphilis by examining the blood microscopically.—*Med. Times and Gaz.*, January 27, 1872.

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Obituary Record.—Died December 26, 1871, in his 88th year, the justly celebrated ophthalmologist, Professor Jaeger. He was very skilful as an operator, and continued until an advanced age to perform the most delicate operations with surprising precision and firmness of hand.

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A few notices of the previous editions are subjoined.

America has of late years been celebrated for the amount of work done on this subject, and Dr. Thomas's volume is the latest, and, we think, one of the best books on diseases of women published in that country. It is a carefully considered and talented volume, up to the latest information, and especially good as regards the treatment recommended.—*Brit. and For. Medico-Chirurg. Review*, Oct. 1871.

No work on Diseases of Women by an American author has met with so distinguished a success, or has so well merited the favor it has received, and in few books is there less occasion for apology in the preparation of the second edition than in this, yet it is but just to the author that it should be understood, that only six months had elapsed after the issue of the first edition, before a second was called for. We have little hesitancy in adopting Dr. Thomas's views on this subject, as upon most others to which he has given his thoughtful attention. A bold and strong mind in the determination of truth are associated in him with a clearness of statement and graphic power in description, that eminently qualify him to instruct. We therefore very cordially recommend his book to all who wish to pursue this branch of study.—*Baltimore Med. Journal*, Dec. 1870.

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HENRY C. LEA, Philadelphia.

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GUERSANT ON SURGICAL DISEASES OF INFANTS, ETC. 16 PAGES.

CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Infantile Paralysis and its Resulting Deformities. By RICHARD BARWELL, F.R.C.S., Surgeon to Charing-Cross Hospital.

GENTLEMEN: Before showing you one or two cases and reading to you certain short extracts from my note-book, it seems desirable that I should define the class of malady which I intend to bring before you. Infantile, like adult, life is liable to certain diseases of the brain and spinal cord which result in loss of power in one or more limbs. But, besides these, the infant is subject to a form of paralysis unattended by any symptom of illness—certainly of severe illness; and this, the class of case I propose for your study, being peculiar to the infant, alone deserves the name of "infantile paralysis." Other paralytic maladies, whether occurring in senility, in the prime, or in infancy, should be classed in the categories of meningitic, myelitic, lead-poisoning, traumatic, or other form of disease. But to enable us to separate one thing from a heap of others, we must have means of recognizing that single object whenever we may see it. Hence there devolves on me the ungrateful task of making a definition out of mere negatives; for the typical, and, in my experience, the common, form of the disease is, that the child should be put to bed perfectly well at night, and next morning be taken up with loss of power over a limb or part of a limb, yet otherwise quite well or only very slightly ailing.

For example: This child, Eva H., aged thirteen (March, 1871), looks extremely healthy, except that she is lame from paralysis of the left leg. Her mother, an intelligent, clear-headed woman, says: "When she was about eighteen months

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old I took her out of bed one morning and put her on the floor to walk. She tumbled down. I thought she was stupid, and put her on her feet again. She fell at once, and I then found her leg was paralyzed. She was not at all ill or fretful, either the night before or that morning; but I think that side of her body was perhaps a little tender."

Agnes P., whom you have often seen, was, when she first came, nine months old, a plump and as healthy a baby as ever I saw, except loss of power in the deltoid of the right arm. The mother says: "Two months ago I took the baby out of bed, and it did not move the arm. I showed it to the doctor, and he said the child must have been hurt. I do believe the girl I had then, lifted it up by the arm; but the baby did not cry either the night before or that morning more than usual. She always cried when she was being undressed and washed. I observed no difference in that, and she seemed quite well."

One more history from my note-book:—

Louisa R., brought to me in April, 1870, when seven years and a half old, with foot deformity resulting from paralysis. Her mother, an active-minded and very acute woman, says that one very hot day, when the child was about eight months old, she was put asleep under a tree on the lawn, and on a damp cushion. The next day she was taken up with the right leg paralyzed. The child had not then any sign of illness whatever, and always has been, with that exception, a strong, healthy girl.

Of such cases and histories I could give you almost an unlimited number. Some attacks may have been preceded for an hour or two, perhaps even for a day or two, by some slight disturbance, fretfulness, a hot skin or mouth, even a slight convulsion. On the morning of the discovery there may be some evidence of pain in the affected limb, some feverish disturbance, and the disease itself may affect a larger or smaller portion of the body. But the more the history and concomitants depart from the type which I have given above, the more any disturbance approaches absolute illness—especially if convulsions have been frequent and severe—the more the stricken regions resemble the relationship of hemiplegic or paraplegic parts, the more likely is the case to be an example of myelitis or meningitis, and the less likely to belong to the pure infantile paralysis, which, as you have seen, does not exhibit a single symptom of central nervous disease.

I feel bound to insist strongly on this distinction, because medical opinion has of late years more and more agglomerated around the idea, fallacious in origin and in result disastrous, that all these cases are dependent on cerebral or spinal disease. Heine, Fliess, Laborde, Radcliffe, and many others, have upheld this notion; and I must shortly point out what essential differences separate this disease from spinal affections. But first, as to pathological appearances. Only seven cases of anatomical investigations have been published. In four of these nothing was detected; in one, that of Dr. Fliess (*Journal für Kinderkrankheiten*), was found a congestion which, emanating from the gums of the teething child, was continued on to the membranes of the cord. It need hardly be pointed out that the preconceived ideas which aided this description are more easily comprehensible than the anatomy of the congestion. To the other two post-mortem examinations I must unfortunately also take exception, for the two cases which form the groundwork of Dr. Laborde's treatise, "La Paralysie (dite Essentielle) de l'Enfance," are cases respectively of myelitis and meningo-myelitis, with their characteristic histories and symptoms, and do not belong to the disease under consideration. The absence of illness and of danger to life renders it improbable that morbid anatomy will ever furnish a clue to the causalty of this disease; we must, at all events for the present, be content with studies from life.

The children we have now to do with are not ill, have no severe convulsion, insensibility, nor pain; therefore no disease marked by severe symptoms, such as myelitis or meningitis, can be present. But a congestion of the cord does not give rise to any attack of such suddenness and

severity; it may also be supposed to vanish at death after having produced paralysis in life. There is, too, a certain similitude between congestive and infantile paralysis—such as immunity of the respiratory muscles, bladder, and rectum. Nevertheless, when the condition of a patient with congestion of the spinal cord is compared with a case of infantile paralysis, the observer will not fail to mark a vast difference between the plump limber limbs of the one, and the cold, shrivelled, flaccid muscles of the other. A further investigation into the condition, more especially by various modes of electricity, will render prominent other and more radical differences. A rapid view may best be given by arranging these into opposite columns.

Spinal Congestion.[1]	Infantile Paralysis.
Paralysis incomplete—always at first, and generally throughout the case; it tends, however, to deepen.	Nothing can be more utter and entire than the loss of power at the very commencement; it tends, however, to lighten.
Generally paraplegic in form at the end, if not at the beginning. Usually one leg is attacked first, then the other. The malady becomes more extensive as it goes on.	Paraplegic form is not usual at the commencement, still less afterwards. When the disease has attacked one part, it never subsequently affects another. It is most extensive at its commencement.
Tingling in fingers and toes.	I have never been able to detect the slightest sign of pain or discomfort. In a few cases there is a little and a doubtful increase of sensibility to touch.
Shortness of breath not infrequent.	No alteration ever observed in breathing.
Fluctuations towards better and worse occur in all cases; sometimes these are rather frequent.	No change, backward or forward, ever occurs; if the patient gain a step, he does not lose it again. (Effects produced by treatment are not referred to.)
There is a decided tendency to relapse, even after the patient appears to have got well.	No tendency to relapse. I have never seen or heard of a limb being paralyzed a second time, nor of another limb being the subject of a second attack.
Reflex irritability is, according to some authorities, increased—according to others, decreased.	Reflex irritability is so utterly annihilated as to leave no room for variety of opinion.
No wasting of paralyzed muscles.	Extremely rapid wasting of paralyzed muscles, setting in very quickly after the attack.
No marked impairment in affected muscle of electro-contractility.	Remarkable impairment of electro-contractility—indeed, total loss of response to the induced current.

[1] The symptoms of spinal paralysis are taken from Reynolds's System of Medicine, vol. ii. p. 663 *et seq.*

These differences are very marked, and so important that the first six alone appear to separate nosologically the one disease from the other; but it is to the last three that I would especially direct attention. They are physiologically connected in infantile paralysis. The induced current ceases entirely to call forth any contractions of the paralyzed muscles in from twelve to seventy-two hours. At the same time there is developed an abnormal sensibility to the voltaic current. Now this peculiar behaviour never occurs in cases of central paralysis, but is exactly what happens when a nerve supplying a muscle has been divided; moreover, both muscles—*i. e.*, the one whose nerve has been cut and the one paralyzed by this malady—lose all excito-motor contractility. But when a nerve of a warm-blooded animal is cut, the muscle, at first flaccid, becomes very hard and strongly contracted as long as the wound remains unhealed. When this is well the muscle relaxes. The nearer to the spine be the wound the harder and more contracted will be the muscle, and the less rapid is the loss of sensibility to the induced current. If we divide the nerve close to its entrance into the belly of the muscle we find hardly any rigidity, quick loss of galvano-contractility, and rapid wasting. Therefore, if we could go a little further and destroy the nerve absolutely at its distribution among the muscular fibres, we should, in all probability, carry the above three characteristics of infantile paralysis—namely, flaccidity, irresponse to faradaism, and wasting—as far as they are developed by the disease itself.

It appears impossible to escape the conclusion that infantile paralysis is a

malady purely peripheral, affecting the ultimate nervous fibrillæ of distribution in the muscular elements. I am anxious, gentlemen, that this conclusion be not pushed too far. I am not supposing or imagining any degenerative or structural change in the nerve-fibres as the cause of this malady. The attack is too rapid and too quickly succeeds exposures to warrant such an idea. The essence of the disease probably lies in some subtle derangement of relationship between ultimate nerve and ultimate muscle-fibre; perhaps from some inflammatory, but more probably from a chemical or nutrient change. In after years any amount of tissue degeneration may occur.

Allow me now to refer to a former remark, and to explain its intention. A few paragraphs ago I said that the prevalent notion concerning the central origin of this malady was in its results disastrous, and in saying this I refer especially to the effects produced by loss of time. In the first few hours of the attack the affected muscles are still sensitive to the faradaic or interrupted current. This sensibility rapidly declines, and I am not aware that any use of this force would prevent its extinction. After a time, which varies in different cases, there is established a sensibility to the voltaic or battery current, and it is upon this that we must rely as our chief aid in the treatment of the disease; and a judicious practice, by keeping alive this contractility, preserves the muscle from extreme wasting and degeneration. To wait, with temporizing treatment, or with none at all, until this sensibility is, in its turn, extinct, is the disastrous result of the belief I have combated. Delay in applying the treatment pays a heavy percentage in subsequent difficulty and duration. Very few cases get well of themselves, and tissue change, as evidenced by the wasting, begins almost immediately. If, then, a child, within twenty-four hours of its first attack, do not already show marked signs of recovery, not merely in one or two, but in every muscle, the state of the case should be carefully and rigorously tested by faradization, and again in another twenty-four or forty-eight hours. Any muscle which, at the end of thirty-six or seventy hours, has ceased to respond, or responds more feebly than at the last examination, will not of itself get well, and to delay treatment is in all probability to condemn the patient to a crippled existence. No disease is so obstinate when old; but while still new, few are more amenable to treatment.—*Lancet*, Feb. 24, 1872.

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The Bruit du Diable.—Abstract of a Clinical Lecture by Dr. A. Duchek, Prof. of Medicine in the University of Vienna.—There are to be found murmurs in the heart and veins which do not take their origin in organic changes of the heart and the vessels—as, for instance, with men and animals exhausted by loss of blood and attendant anæmia. In the same degree as the loss of blood and the paleness of the skin proceed, these murmurs appear in the heart and the veins of the throat. If we touch, in severe cases, the vena jugularis with the finger, we perceive a continued vibration, like that of a string. This vibration is not interrupted, as we observe it in arteries, but continued. On pressure on the upper part of the vena jugularis, both the perception of the vibration and the acoustic evidence of a murmur disappear, proving it to be merely venous.

The formation of the sounds in the heart is influenced by two agents: the condition of the valves of the heart and the vessels on the one hand, and by the pressure produced by the blood-stream upon them on the other. As we have, in such cases of anæmia, no symptoms permitting us to diagnose changes in the vibrating mediums, we are induced to seek the origin in the cause itself which produces vibration—namely, the pressure of the blood. In disorders attended by these murmurs (as anæmia, chlorosis, loss of blood), the propulsive power of the heart is unchanged, though its contractions are more numerous, while the blood, either in its quantity or quality, is lessened, and consequently the pressure exercised by it in the circulation is diminished too, so that the impulse given by the blood-column is not sufficient to develop in the valves or the arterial walls the amount of

tension necessary for the formation of the sound, which under normal circumstances makes its appearance in these vibrating mediums, but in these cases is lowered into the acoustic impression of a murmur.

In this way we explain the murmur in the heart. It is more difficult to find its cause in the vena jugularis. Some have attributed it to the arteries; but this is contradicted by its disappearance on pressure on the jugular vein, and by its continuity. This bruit is modified by two causes. It grows stronger at regular intervals, corresponding to the pulse, being strengthened by the sound of the carotids; we call these simply moments of reinforcement. The second cause is the respiration, which, when accelerated, influences the murmur.

What is the origin of this murmur? In the heart we explain all sounds and murmurs by vibrating membranes. We shall not suppose that in the veins a whirl of blood is their cause, nor the pushing of the blood against a narrow entrance. The jugular vein behind the insertion of the sterno-cleido-mastoideus is wider than elsewhere, forming the bulbus. Beneath this bulbus are valves in the narrowest part of the vein. These valves have a most important influence upon the whole circulation of blood. The pressure in the thorax being too high, they approach one another, and in this way oppose the further entrance of blood into the thorax. The part above them must be, consequently, dilated, as we remark it in cases of stagnation in the heart, the jugular vein being distended, and the jugulum growing gradually more shallow. The impulse of the blood makes these valvulæ vibrate, and causes the murmur. When the blood flows slowly the impulse is too weak, and no murmur is to be heard, just as a slight touch is not sufficient to make a string vibrate audibly. The murmur arises when the valvulæ are half opened and put into vibration by a sufficient rush of blood. Another peculiarity is to be mentioned. The bulbus is attached to the clavicula behind the articulatio-sterno-clavicularis; and thus being stretched out, it facilitates the flow of the blood. If the pressure in the thorax increases, by valvular failures, emphysema of the lungs, &c., the stream flows slowly, and therefore we do not find these murmurs attending disorders of the intra-thoracic organs, and hence the general view that this bruit excludes insufficiency of the valvula mitralis. Another consequence of this fact is, that these murmurs are not to be heard in persons affected by anæmia when they become the subjects of pneumonia, or exudative pleurisy, and that they reappear at recovery. The two necessary requisites, then, are a speedy circulation of blood and a normal pressure of the blood in the thorax. This view affords us also an explanation of the murmur growing stronger when the respiration is more hurried. The thorax being powerfully dilated, the blood rushes in strong streams towards it, strengthening the acoustic impression. When the respiration is impeded, when it must be forced, the circulation loses the necessary quickness, and the vibration of the valvulæ becomes inaudible.

These murmurs are very rarely to be found along with mechanical changes in the heart. They accompany similar murmurs at the ostia, which are always systolic, never diastolic. They may be perhaps diastolic, but only in the most severe disorders of this kind, where it is impossible to distinguish whether there is only one continued murmur or whether the systolic and diastolic murmur meet and run into one another.—*Lancet*, Feb. 3, 1872.

HOSPITAL NOTES AND GLEANINGS.

Ascites Complicating Ovarian Disease.—M. R., æt. 51, widow, mother of seven children, was admitted into the Royal Infirmary, Edinburgh, Nov. 13th, complaining of pain and swelling in the belly, and indigestion. She first remarked the swelling of her belly eight or nine weeks ago; it has increased rapidly since then, and gives rise to pain and inconvenience. Her monthly periods were regular up to the time of the commencement of her present illness, but they have been absent since then.

Present Condition.—The belly measures forty-five inches, the tape being passed

around it over the most prominent part, which is the umbilicus. On palpation and percussion in the usual manner the swelling is found to be caused by fluid, free in the peritoneal sac. No cardiac or other local disease could be discovered to account for the presence of the ascitic fluid.

November 17.—Patient was tapped to-day. Twenty-two pints of fluid of a greenish colour were drawn off. It is found to have a specific gravity of 1020; reaction alkaline; when heated, or on adding nitric acid, it almost entirely coagulates. On keeping this fluid, no coagulum is formed, but a deposit is observed, which, on microscopic examination, is seen to contain round granular cells, varying in size, and generally possessing a nucleus and granular contents. Some of these cells are four times as large as an ordinary red blood-corpuscle. After the tapping, a hard, irregular, nodulated mass is felt, occupying the right iliac fossa, near the site of the right ovary; it is freely movable.

Remarks.—This patient was sent into the hospital, said to be suffering from ovarian dropsy. The great bulk of the fluid, however, was at once made out to lie free in the abdominal cavity, to be what is ordinarily called ascitic. Cases of ovarian dropsy are generally accompanied by some amount of ascites, but in the great majority of them it is trifling, in small quantity. On manipulating over an ovarian cyst, the woman lying on her back, you can generally make out the rounded margin of the cyst-wall, where the dulness of it should end; but the dulness of the free fluid in the abdominal cavity may run into it, and you may thus be unable to distinguish between the two. Place the woman on her side, however, and then the dulness is observed to end at the rounded margin of the tumour, the ascitic fluid having gravitated towards the other side, and what was before dull on percussion is now found to be resonant. Instead of the ovarian dropsy, it was the ascites which predominated in this case. On tapping, it was found to measure twenty-two pints and a half. After tapping was performed, an ovarian tumour was detected, which before was not recognized. The large amount of ascites was probably owing to the disease being, in all likelihood, malignant. Malignant disease seems to cause a great deal more irritation of the peritoneum than simple ovarian tumour. In ordinary cystic disease of the ovary we occasionally observe tubercular peritonitis to be present along with it more frequently than would happen should there be no irritation of the peritoneum, such as is caused by an ovarian tumour. The opinion that the case before us is probably malignant in its character, is founded on the following considerations: 1st. The cachectic condition of the patient—the sallow, anæmic appearance of her face. In advanced ovarian dropsy which is not malignant you have considerable emaciation present, especially about the face, neck, and breasts; but otherwise the general appearance may be healthy. 2d. The feeling and history of the tumour itself. It has a very irregular, hard, nodulated feeling; no big cyst present. There is no definite shape, but merely a series of irregular lumps. It is growing slowly. The age of the patient (51) gives some countenance to the diagnosis.—*Med. Times and Gaz.*, Feb. 17, 1872.

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Bullet Wounds of the Bladder.—Dr. A. E Barker communicated to the Surgical Society of Ireland, Feb. 2, 1872, the following case of this observed in the Klinik of Dr. Busche, Surgeon General in the late war.

P. S., a young soldier, æt. 24, was wounded in the battle of Bapaume, on the 3d of January, 1871. Three balls had entered almost, if not quite, simultaneously in different parts of the right gluteal region. The two lowest openings were about three inches from one another, the third about an inch and a half above a line joining the two lower ones. Two of the balls had evidently left the body, and, strange to say, by almost the same opening in the middle of the left groin, just over Poupart's ligament. The wounds showed that they had made their exit within half an inch of each other, causing in their course injuries to the bladder, for the urine flowed copiously through the

openings in the groin. Whether the third had also passed through one of the openings was impossible to say, but it would indeed be an extraordinary coincidence if the three projectiles entering at such a distance from each other and probably in various directions, should have so converged as to nearly meet just when piercing. It is, however, possible. Of course nothing special could then be done, and he was simply placed on his side and attended to in the expectation of seeing the fearful effects of urinary infiltration setting in. This was far from being the case, however, and after the urine had been for some time flowing off solely through the openings in the groin, it began to come *per urethram* and the wounds in the inguinal region healed with the several others in the most healthy manner. The patient then left the Lazaret apparently quite well, but after a considerable space of time complained of difficulty in passing water. On search being made with a sound, a hard body was discovered far back in the urethra. It was carefully grasped with a fine forceps and extracted, proving on examination to be a piece of bone (probably from the os ilium), about half an inch long, and in one part about a quarter of an inch broad. Fortunately it lay in such a position as allowed of its easy removal. In this manner within a short space of time four similar splinters were extracted, each time relieving the difficulty in passing water, and the man enjoyed a period of rest. After a while, however, he began to complain again, and this time of pain in the glans penis, with the other symptoms of calculus; the urine being much altered. On sounding, a tolerably large stone was discovered, apparently of soft consistence, and it now became a question of importance, as well as great interest, Might not the third bullet be the nucleus of the calculus? The uncertainty and impossibility of determining this, and at the same time the probability of its being the case, pointed, of course, to the extraction through the perineum in preference to lithotrity. As the man's health was already suffering from the distress and bad state of the bladder and urine, it was at once undertaken (Nov. 8, 1871) in the usual manner; but owing to the softness of the stone, and the necessity of grasping it with a small forceps, on account of the prostate being unusually small, the former broke very frequently and slipped, occasioning much delay, the extraction lasting more than half an hour. It was finally removed, however, and the detritus washed out with the irrigator. Then that simple after-treatment, which is always had recourse to here in such cases, and which seems to have so much to recommend its wider adoption, was resorted to, namely: The cut in the perineum washed clean by the stream of water from the irrigator, was allowed to close completely, the legs being brought together, a pledget of charpie moistened in solution of carbolic acid was alone laid over the surface, no catheter or anything else being left in the wound. The patient was then put to bed, lying on his back with his legs flexed on the body and knees flexed over a high pillow, the latter being kept well together, the orders being that whenever he felt the slightest desire to make water he should be helped, in the same position, into a warm bath, and there allow the urine to pass quietly through the opening. The advantages of this method seem so evident, and in all cases were followed by such good results, that they are deserving of mention (if not already known). In this way is avoided the fever produced by the irritation liable to follow from the presence of the catheter in the bladder and wound, the sides of the latter lying together. On the slightest desire to empty the bladder the patient can easily be lifted into the warm sitz-bath, and there do so under water, which has several advantages, first, the air cannot come in contact with either the wound or bladder; secondly, the urine on entering the cut is immediately deprived of its irritating properties, by being diluted and at once washed away, the wound being closed clean by bringing the legs together again. In the same position he is lifted again into bed, the bladder empty, the wound, without having been touched, cleansed from all the pus and urine, and closed from the air. Near the bed of a patient so treated one never perceives the ammoniacal odour

which by those managed in the usual way is commonly present (in spite of the utmost care), owing to the trickling out of the urine and the wetting of the bed-clothes. The only dressing required is a pledget of wet lint. The warm bath, moreover, is in itself most beneficial. With this patient things seemed to go wonderfully well; after a few days the water began to come partially through the urethra, and shortly after ceased to come by the wounds, the latter healing rapidly and cleanly. The condition of the bladder also improved very quickly, and the urine soon became normal, so that in a very short time he would be called almost quite well, when he was attacked with an acute epididymitis on the right side. Under ordinary treatment, however, this too passed away in a few days, and the patient left in good health for his home. The calculus was of the ordinary soft phosphatic composition, and did not contain the bullet as a nucleus.—*The Med. Press and Circular*, Feb. 28, 1872.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Importance of the Absolute Purity of the Agents employed in Chemical Analyses.—A somewhat striking illustration of this is noticed in the New York *Evening Post*, connected with a case recently tried in the superior court of that city.

The matter in dispute was the right to a "trade-mark" for a certain brand of mustard, and Prof. Doremus (whose name often appears on published "certificates" as an analytical chemist) had testified that mustard contains more than eleven per cent. of starch. The *Post* gives the following account of the subsequent proceedings:—

"Two other analytical chemists, one of them Professor Chandler, of Columbia College, alleged that mustard contained no starch. The evidence was in this conflicting condition when both parties rested, and the case was adjourned until the next morning for argument. In the mean time Professor Doremus applied to the counsel of the defendant to move to so far open the case as to allow him to vindicate by actual experiment in open court the correctness of his statement as to the existence of starch in mustard. The motion was made and granted; and at the appointed time the court-room presented the appearance of a chemical laboratory.

"The Professor, with his assistant, prepared mustard for experiment in open court by pounding the seed in a mortar. He placed the crushed seed in distilled water, and boiled the mixture over a spirit lamp. He then threw some of the solution on sheets of filtering paper, applied his chemical test, and exhibited to the court on the paper the characteristic blue iodide of starch. The experiment was varied in many ways with the same result, and at the end of the testimony many sheets of paper were thus coloured. The demonstration seemed perfect. On Professor Chandler being called to the stand he made experiments which, in his view, demonstrated that starch did not exist in mustard, and stated that he was not satisfied with the experiments that had been made by the defendant's witness.

"'Why,' said the defendant's counsel, 'are you not satisfied with the reaction for starch exhibited by Dr. Doremus on the dozen or more sheets of filtering paper?'

"'I am not certain, to begin with,' said Professor Chandler, 'that the paper would not have produced that reaction without the mustard.' Whereupon the counsel handed to the witness some of the clean paper, and asked him to apply the test to it himself. He did so, and the result was a deep blue, thus showing the illusory nature of the prior tests, and that the experiment was entirely worthless as proof that starch was contained in mustard."—*Boston Jour. Chemistry*, March, 1872.

American Medical Association.—Active measures are being taken by the medical profession of Philadelphia to insure a pleasant visit to their guests at the ensuing meeting of the American Medical Association. The programme, as now arranged, comprises a reception similar in character to the one given in May, 1870 (see *Med. News*, June, 1870, p. 90), by the Biological Section of the Academy of

Natural Sciences, and a promenade concert at Horticultural Hall on Tuesday evening, May 7th. On Wednesday and Thursday evenings, in addition to the usual private entertainments by citizens, there will be given very interesting lectures on the spectroscope, gas microscope, the recent discoveries in electricity and galvanism, etc. And on Friday the members of the Association, with their ladies, will make an excursion to Fairmount Park, and along the banks of the Schuylkill.

A visit to the iron-clads at League Island is proposed.

The Alumni of the University of Pennsylvania and of the Jefferson Medical College will each avail themselves of the meeting being held in Philadelphia to have a reunion.

During the sessions of the Association there will be held in the Hall of the College of Physicians an exhibition of objects of interest and instruction, such as recent inventions and improvements in surgical and obstetrical apparatus and appliances, optical, ophthalmological and other instruments of precision, philosophical and electrical instruments and apparatus, new chemical and pharmaceutical preparations, anatomical and pathological specimens, models, and other means of illustration, and new books, prints, and other publications. The chief design of this exhibition, which it is hoped will be held annually hereafter, is to show the recent progress in, and present status of, these respective branches of knowledge and industry. We earnestly hope that gentlemen who have objects of especial interest or recent origin, in these different classes, at their disposal will at once avail themselves of this opportunity to bring them forward, not only for their own benefit, but for that of the profession generally. Contributions are invited from all parts of the country. Any information wished by gentlemen desiring to exhibit may be obtained by addressing Dr. Wm. Pepper, 1215 Walnut Street, or Dr. F. F. Maury, 1218 Walnut Street, Philadelphia.

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Philadelphia Hospital, Blockley.—Prof. A. Stillé has resigned his office as Visiting physician to this hospital, and the managers have passed a resolution thanking him for the efficient services rendered while connected with the institution.

Dr. Jas. Tyson has been elected visiting physician in place of Dr. Stillé.

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Graduates in Medicine in 1872.—

University of Pennsylvania . .	83
Jefferson Medical College . .	114
College of Physicians and Surgeons, N. Y.	78
University of the City of New York.	75
Bellevue Hospital Medical College .	129
Ohio Medical College. . . .	87
Miami Medical College . . .	67
Rush Medical College (Chicago) .	77
Med. Dep. University of Buffalo .	34
Cleveland Medical College, Ohio. .	34
Med. Dep. of Georgetown College .	20
Medical College of Virginia . .	12
National Medical College (Washington)	7

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Mortality from Smallpox in Philadelphia.—

For the week ending March 2, . .	121
" " " " 9, . .	118
" " " " 16, . .	120
" " " " 23, . .	94

It will be perceived from the above statement that the epidemic of smallpox has very materially diminished in this city.

—

The Presbyterian Hospital in Philadelphia.—At a recent meeting of the Board of Trustees of this new hospital the following staff were elected: *Consulting Surgeons*, D. Hayes Agnew, M.D., Saml. D. Gross, M.D.; *Consulting Physicians*, J. L. Ludlow, M.D., J. M. DaCosta, M.D.; *Attending Surgeons*, Thos. B. Reed, M.D., Oscar H. Allis, M.D., H. Lenox Hodge, M.D., Wm. G. Porter, M.D.; *Attending Physicians*, Ellerslie Wallace, M. D., S. Weir Mitchell, M. D., James Markoe, M.D., D. F. Woods, M.D.; *Obstetricians*, Robt. M. Girvin, M.D., John S. Parry, M.D.; *Ophthalmic Surgeons*, W. Wallace Maclure, M.D., Geo. Strawbridge, M.D.; *Pathologist*, De Forest Willard, M.D.

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Failure of Condurango.—Dr. A. J. Stewart, of Petalumna, records (*Pacific Med. and Surg. Journal*, Jan. 1871) two cases

of cancer unsuccessfully treated by this vaunted specific.

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"*Jackson's Cough Syrup.*"—It is stated (*Cincinnati Lancet*, March, 1872) that the formula for this preparation has not been uniform, and therefore the Cincinnati College of Pharmacy has recently presented to the Academy of Medicine the following formula as an uniform standard, indorsed by the secretary, Mr. James M. Ayers:—

℞. Fluid extract Ipecac ℥ss.
Fluid extract senegæ (℥j Rad. Senegæ to f℥j) ℥iij.
Fluid extract rhei ℥lv.
Syr. simplex ℥xxxj.
Morphia murias gr. viij.
Ol. sassafras gt. xxxlj.
M. ft. mistura.

We may remark that this is altogether different from the preparation made in Philadelphia, according to Prof. S. Jackson's formula.

—

The Western Lancet.—This is the title of a new monthly medical journal, edited by Drs. Eustace Trenor and Herman P. Babcock, of which only the second number, published in February last, has reached us. That number is very neatly gotten up, and contains some interesting papers. We wish this new candidate for professional support success, and welcome it to our exchange list.

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L' Union Médicale du Canada.—This is the title of a monthly journal published in Montreal, and edited by J. P. Rottot, M.D. The first number appeared in January last. We welcome it to our exchange list.

—

Obituary Record.—Died at Peekskill, New York, Feb. 14, Charles A. Lee, M.D., aged 70 years. Dr. L. was a learned physician and contributed largely to the literature of our profession.

—— at Syracuse, New York, Feb. 18, John Foote Trowbridge, M.D., aged 80 years. Dr. T. was a highly esteemed and skilful physician.

FOREIGN INTELLIGENCE.

On Dyspepsia of Liquids.—Dr. Thorowgood records (*Lancet*, Feb. 17, 1872) several cases which he considers to be good illustrations of that indigestion of liquids which has been carefully described by Chomel in his work on Dyspepsia. The affection, in its fully developed form, he does not believe is common in this country, though he has met with several cases in the course of the last few years. The following is one of them: James M'C., aged 30, a pale, dark, intelligent man, came under Dr. Thorowgood's care, complaining generally of dyspeptic symptoms, and especially of the great uneasiness caused by the presence of any amount of liquid in the stomach. Liquids in the slightest degree acid were most distressing to him, and at times he had attacks of sour pyrosis. He complained much of dryness of mouth, with dry skin and costive bowels, urine loaded with lithates, but free from traces alike of sugar or albumen. No loss of flesh; pulse slow and soft; nothing irregular to be found in heart or lungs; no sort of tumour or thickening about pylorus, but on gently vibrating the stomach, fluid was heard splashing about in it, and this sound could be always produced irrespectively of any liquid having been recently ingested. The stomach was much distended. The early treatment of this case consisted in the use of alkalies with bismuth and various bitters, but no improvement resulted: the only noteworthy feature was the effect of a pill of extract of opium at night, which regulated the action of the bowels so completely that the patient asked for the pills as *aperient* pills. It was afterwards agreed that the patient should drink as little as possible, and take no other medicine than a powder of rhubarb and magnesia every morning. From this time he steadily improved, and after about two months' treatment he appeared to be cured, and was, six months afterwards, still in good health. Dr. Thorowgood considers the dry plan of diet the only one likely to be followed by any amelioration of the symptoms; and until this is tried, no medicine will prove of any service. At times fits of faintness, with irregular action of the heart, are prominent symptoms in these cases of dyspepsia of liquids, the cause being due to the distended state of the stomach. The patient must bear

a certain amount of thirst as well as he can, and take but small quantities of liquids at a time, and not drink for an hour or more after he has taken his meal of solid food. Weak whiskey and water, sherry wine, and toast and water, are amongst the least objectionable drinks; and sometimes a small cup of good beef-tea, free from any farinaceous admixture, will suit well. One of his patients found a wineglass of good stout to agree well and relieve his thirst.--*Practitioner*, March, 1872.

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Diagnosis of Syphilis by the Microscope. —In our preceding number, pp. 46–7, we gave an account of the researches by Dr. Lostorfer on this subject, communicated to the Vienna Medical Society (Jan. 12, 1872). At a meeting of the same society on Feb. 9, the subject was further discussed. Prof. Wedl contested the accuracy of Dr. L.'s discovery which would be of great importance if confirmed, but he made some researches which did not confirm them. Dr. Wedl had examined specimens both of syphilitic and of healthy blood; and in both he had found the corpuscles described by Dr. Lostorfer. He had shown these to Dr. Neumann, Prof. Gruber, and Dr. Blau; and each of these, having separately examined the corpuscles, had recognized them as those which had been shown to them by Drs. Grünfeld and Lostorfer as syphilitic corpuscles. These corpuscles had a diameter ranging from 1-5000th to 1-12500th of an inch; their contour was sharply defined, they refracted light strongly, and had a greenish blue tinge. He believed them to be oily corpuscles; and this opinion was confirmed by observing particles of the same kind in some "mistura oleosa" examined under the microscope. Dr. Lostorfer had also described other bodies having an irregular form; these Dr. Wedl recognized as portions of the secretion of the sebaceous glands. With regard to the vacuoles, by which the corpuscles were said to become surrounded, he believed that they were the result of a destructive process. The formation of vacuoles was induced by the separation of water, and by carbonate of ammonia, in septic decomposition of the blood. By heating broken-up human fat with solution of potash, the production of vacuoles could be followed through its stages. The statement that these corpuscles increased in circumference was incorrect. Dr. Lostorfer had probably lost sight of the corpuscles which he was observing, and had seen other larger ones, which he believed to be the same. That Dr. Lostorfer did not meet with the corpuscles until several days had elapsed, might be due to their having been rendered indistinct by the presence of a large number of blood-corpuscles. If the latter had been washed out by a stream of distilled water, the others would without doubt have been at once observed. As to the manner in which these fatty particles came into the blood, Dr. Wedl believed that they were derived from the cutaneous secretions. It was impossible to avoid this admixture if a mere puncture of the skin were made; a vein should be opened and the blood withdrawn through a canula, and even then one could not be sure of obtaining it pure. In coming to the conclusion that Dr. Lostorfer's observation was not correct, he (Dr. Wedl) had kept his eye on the facts, without regard to the person. No one would have rejoiced more than he if the discovery had been proved; it would have been of greater value than the discovery of a new planet; it would have raised the fairest hopes of discovering specific bodies in the blood in other diseases.

Prof. Stricker asked whether the fatty or protoplasmic particles described by Dr. Wedl were identical with those seen by Dr. Lostorfer. To ascertain this, Dr. Wedl should have examined the latter bodies; until this was done, the matter must remain in suspense. The statement of witnesses, that the corpuscles in the two cases were identical, was not a sufficient guarantee; a competent judgment could only be formed by skilled microscopists. He had examined these corpuscles with the best lenses, and did not venture to assert that they were germs or fungi. He had placed a hundred specimens before Dr. Lostorfer, who had correctly diagnosed those taken from syphi-

litic patients, with the exception of twenty doubtful cases. He moved that a committee should be appointed to investigate the subject.

Prof. Wedl said that he would have willingly examined Dr. Lostorfer's corpuscles for himself, had he not been too much occupied.

Dr. Lostorfer asked whether Dr. Wedl had seen the corpuscles in fresh blood. He (Dr. Lostorfer) had expressly stated that they first appeared in four or five days. If Dr. Wedl had seen them in fresh blood, he thought that they could not be the same as those which he had described.

Prof. Wedl replied that the corpuscles were present in fresh blood. The reason why Dr. Lostorfer did not see them was, that they were overcrowded by the red blood-corpuscles.

Dr. Neumann said that nearly four years ago Hallier described structures in the blood in infectious diseases, and also in syphilis; he said that these gave rise to syphilis, and that their most minute elements penetrated the blood-corpuscles and rendered them diseased. These corpuscles multipled by division, assuming the characters of *coniothecium*. Hallier had found them in syphilitic paronychia, in condylomata, and in other manifestations of syphilis; Oklotsch had also found traces of them in the skin as well as in the blood. The importance of such a discovery, if it were established, must be very great to the practitioner, in regard not only to syphilis, but to other contagious diseases. He had therefore visited Hallier, in order that he might learn the characters of the syphilitic microscopic cellule. The result of experiments which he made with specimens of blood from persons presenting various forms of syphilis was, that *bacteria* were developed in the blood-corpuscles of the infected blood, which in no respects differed from those developed under similar circumstances in the blood from other contagious diseases even after so long a period as five months, these organisms multiplied in their own form, and, in spite of the addition of various organic and inorganic substances, no fungi were found. Since Dr. Lostorfer had announced his discovery, he (Dr. Neumann) had made fresh investigations, and found that the corpuscles might be developed in various numbers and sizes in different kinds of blood. He had found them in the blood in smallpox, eczema, etc.; and, therefore, they could not be regarded as a specific indication of syphilis.

Dr. Geber had made examinations of the blood in various diseases, having first made himself thoroughly acquainted with the appearance of the corpuscles described by Dr. Lostorfer. In company with a colleague, he examined the blood of a variolous patient, and found in it corpuscles quite analogous to those presented in syphilis. He was still engaged in experiments, of which he would communicate the results at a future date.

Prof. Gruber had seen the corpuscles described by Dr. Lostorfer and also those described by Dr. Wedl; and he had no doubt of their perfect similarity. If there were any peculiarity in the corpuscles of syphilitic blood, it was too subtle to be detected by the microscope.

The discussion terminated with the appointment of a committee to investigate the subject, consisting of Aulic Councillor Dr. Rokitansky (President); Professors Brücke, Billroth, Reichert, Karsten, and Klob, and Drs. Bausch and Auspitz. —*Brit. Med. Journ.*, Feb. 24, 1872.

The *Wiener Med. Wochenschrift* says that the above committee have been dissolved, the members appointed having declined to perform the duty assigned them.

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Digitalis an Anaphrodisiac.—M. Gourvat is publishing, in the *Gaz. Méd. de Paris*, a series of papers on the action of digitalis. In a late number (Dec. 23, 1871) we find the following: "When digitalis or digitaline is administered for some time to a man in full possession of sexual powers, the latter become gradually weakened, the propensities disappear, the secretion of the liquor seminis diminishes by degrees, and may at last vanish altogether. These results are explained by the antiplastic and lowering action of digitalis. The antiphlogistic properties of the drug are the secret of its good

effect in spermatorrhœa. With women, digitalis and digitaline excite strong, regular, and intermittent uterine contractions, and control metrorrhagia; hence digitalis is employed in exciting abortion. (Tardieu.) It is probable that digitalis acts as an anaphrodisiac in women also; inducing, by long-continued use, impotence and sterility. In men it hinders the secretion of the liquor seminis, and in women it may interfere with the development of the Graafian vesicles, the propagation of the species being thus doubly retarded.—*Lancet*, Jan. 13, 1872.

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On a Form of Fracture of the Bones of the Face, and its Diagnosis.—By M. Dubrieul. Certain injuries of the face are followed by anæsthesia of half of the upper lip. Different theories as to the nature of the accident are held. Jarjavay considers it a symptom of fracture of the malar bone; Richet, of the upper jaw bone, and connects the symptoms with a lesion of the infra-orbital nerve. I have dissected two cases of destruction of the infra-orbital nerve, coincident with the following lesions of the bones of the face. The first died so soon after his injury, without ever passing out of his state of coma, that I was unable to assure myself by experiments that the upper lip was insensible; the other lived for a month and a half, and by many experiments I proved the complete insensibility of his left upper lip; he did not feel the entrance of a pin into that part, usually so sensitive. In his case the infra-orbital nerve was completely destroyed at its exit from its canal; in the first it was divided in the centre of the canal. In both cases there was a marked flattening of the zygomatic arch. In both there was a fracture of the malar bone, above the upper jaw bone, at its outer and upper wall, the internal wall and alveolar margin being left entire. Such accidents are the results of antero-posterior violence, such as a fall upon a pointed object, or a severe blow with a fist.—*Edin. Med. Journ.*, Jan. 1872, from *Gaz. des Hôpitaux*, No. 69, 1871.

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Glue Bandage as a Primary Setting for Fractured Limbs.—Dr. George Ross, of the Montreal General Hospital, states (*Canada Med. Journ.*, Dec. 1871) that the use of the glue bandage has been introduced into the Montreal General Hospital within the past three months. The method of applying the bandage he thus describes: Some good suitable glue is procured—the best for the purpose is Cooper's No. 1 white English glue, or else some of the finer sorts in thin sheets, which are manufactured in this country; it is prepared by first soaking in water for an hour or two, and then melting in a common carpenter's glue-pot; also some fine sheet-wadding, and several rollers made of thin cambric or old worn cotton (new cotton is objectionable, for it will not soak up the glue so thoroughly, and will make a less firm bandage). The limb is then entirely swathed in a thin layer of wadding made by splitting the ordinary sheet in the middle to avoid unnecessary bulk, and then whilst carefully held in position by an assistant, the first roller is applied in the ordinary way; this done, it is smeared all over by a brush, or better still by the hand, with a good layer of the melted glue to which one-fifth part of alcohol has been added to accelerate the evaporation. The second roller is then applied, and in like manner coated thickly with glue. Some strips of bandage, ten or twelve inches in length, are then thoroughly soaked in theglue and placed over the seat of fracture, some vertically and others diagonally, so as still further to strengthen this part. The third roller is finally secured over the whole and covered with a thick coating of glue.

It is necessary now to sling the limb so that the air may have equal access on all sides to dry it. I have found that the outside coating will become quite dry in from three to five hours, when the sling may be removed, but the entire thickness of the bandage will not be found entirely consolidated for about forty-eight to sixty hours. After the lapse of this time, the leg is found to be encased in a perfectly fitting boot, more solid than the thickest sole-leather, and can be moved in any direction without pain. In none of the cases has there been any complaint of pain from the swelling that we might expect to find occur shortly

after a fracture had been sustained. On the contrary, the patients have all expressed themselves as feeling extremely comfortable. As soon then as the bandage has completely consolidated, it becomes necessary to split it down the front from one end to the other. Owing to the extreme hardness of the splint, this is a matter of some difficulty, except in the event of one's possessing a pair of powerful properly-constructed bandage pliers: failing this, however, the simplest plan is to slip a very thin piece of wood beneath it, and then cut on this with a sharp strong knife. Having thus split the bandage from end to end, a number of holes are bored on either side with a brad-awl, and a long tape being passed alternately through these, it is laced up like a lady's corset. The apparatus is then entirely complete, and may remain without being touched until union is perfect. The above description might lead some to suppose that the process was long and tedious, and in consequence objectionable, but our small experience with it in this hospital is such as to make us believe that by reason of its increased comfort to the patient, and of the fact that patients can sooner get up with safety with this than any other form of splint, and that it will never get out of order, and consequently never require re-adjustment, the advantages secured by its employment greatly counter-balance any slight trouble that it is necessary to take to insure its proper application at first.

At this hospital, the above-described method has been put into practice in several cases of simple and compound fracture of the leg, and in all with most satisfactory results. In the majority of cases, the patients were permitted to get up on crutches on the third day from the receipt of the accident. In two, it was thought advisable to make use of a box splint for a few days previous to the application of the bandage on account of considerable swelling and rapid vesication.

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Artificially induced Epilepsy in Guinea Pigs.—In the course of some recent experiments on the establishment of artificial epilepsy in guinea pigs, Dr. C. Westphal has been over the same ground as that explored by M. Brown-Séquard, and fully corroborates the results at which the latter observer arrived. He adds, however, some new and interesting facts. Thus he found that if one or two slight blows on the side of the head are given to a guinea pig, they are sufficient to bring on an epileptiform attack, after which the animal again recovers its liveliness, or it remains heavy for some time, and then exhibits a kind of rotatory movement, like those shown by Schiff to occur in rabbits after lesions of the crus cerebri. If the blow be too violent, the animal dies with or without convulsions, but always with arrested respiration, the heart continuing to beat for some minutes, and life may be preserved, though usually only for a time, by artificial respiration. If the animal survives the blows, a similar epileptigenic zone is created as in the guinea pigs treated on M. Brown-Séquard's method by lesion of the medulla oblongata at certain points, or section of the sciatic; and, as in these last cases, the zone is near the angle of the lower jaw. Before the zone is well established, and four weeks are usually required for this purpose, the animals betray the presence of some irritation at this part by frequently scratching it. After it is established, slight pinching will induce tonic and clonic spasms, though the sensibility of the skin is here diminished. The rapidity with which the zone can be established may be increased by striking the animal's head on successive days, and the excitability of the zone endures for a period varying from six weeks to six months. The condition is hereditary. M. Westphal set himself to ascertain the nature of the changes induced by the blow or blows. That the condition is not produced by any alteration in the integuments is shown by the circumstance that the fits occur when the exposed skull is struck. Careful examination of the brain also furnished no clue to the mystery. But on examining the medulla oblongata and spinalis cervicalis, and even sometimes dorsalis, he found small hemorrhages both in the white and gray matter to be of

constant occurrence, and there was usually also hemorrhage into the sac of the dura spinalis. These small hemorrhages appear to induce the primary attack of epileptiform convulsions, and the changes occurring around them to lead to the formation of the epileptiform zone; but *how* or *why* is not yet capable of explanation —*Lancet*, Feb. 10, 1872.

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Echinococcus in the Orbit.—An interesting case of this disease was brought before the Medical Society of Vienna at the meeting held on Feb. 9th. It had been originally under the care of Arlt, but was transferred to Billroth. The patient was a boy aged thirteen years. He had suffered for two years from a tumour situated at the outer and inferior wall of the orbit, and which, by its gradual increase, pressed the eye inwards and upwards. The tumour was elastic and somewhat fluctuating. The absence of inflammatory symptoms at any period of its growth precluded the idea of an abscess, and it was imagined to be a vascular tumour of some kind; but on the introduction of a grooved needle, clear fluid alone escaped. It was then regarded as a cyst. Sharp inflammation followed the puncture, and, suppuration occurring, its excision was determined upon. An incision was made over the swelling, which was found to be situated between the periosteum of the orbit and the connective tissue investing the ocular muscles. The cyst was divided, and a vesicle about the size of a hazel-nut protruded, which was soon recognized to be an echinococcus. This makes the fifth recorded case of echinococcus in the orbit.—*Lancet*, Mar. 9, 1872.

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A Mode of Demonstrating Minute Portions of Sugar in the Urine.—Prof. Seegen states (*Centralblatt*, No. 5) that even Trommer's test is not very satisfactory where small quantities of sugar only are present in the urine, and that it does not detect such amounts so readily in urine as in watery solutions, since the whitish cloud that is formed when sugar is really present is undistinguishable from that produced by excess of uric acid. He finds that a great increase of sensitiveness can be produced by filtering the urine through blood charcoal two or three times successively. By this means not only is the colour removed, but the uric acid is almost entirely retained by the charcoal, and then the reduction of the copper by Fehling's test may be very clearly seen. No quantitative estimate of the amount of sugar present can be made after the urine has thus been filtered through charcoal, as a certain portion is retained in the filter.—*Lancet*, March 9, 1872.

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Precocious Development.—Fluegel describes in the *Bayr. ärtzl Intell.-Blatt* (No. 49, 1871) the case of a female child who died of diarrhœa at the age of five and a half years. She was five feet in height. The incisor teeth had all appeared when she was six months old, and at nine months she had all the molars. At a year and a half old, she menstruated; and, especially in her later years, the periods were tolerably regular. The external genital organs were well developed, without hair; the breasts were full, and the pelvis roomy. The condition of the internal genitalia was not ascertained. As regarded her intellect, she did not appear to be in advance of other children of her age, although she had begun to speak when six months old.—*British Med. Journal*, Feb. 24, 1872.

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Dengue.—A severe epidemic of this disease prevails in and around Calcutta. —*Indian Med. Gaz.*, Feb. 1872.

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Cholera.—This disease has been prevaling in the district around Calcutta, appearing suddenly in a village, carrying off several of its inhabitants and subsiding. The city itself has been comparatively free.—*Ibid.*

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International Ophthalmic Congress.—The Congress will meet, the first week in August next, at the College of Physicians, in London.

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Obituary Record. — Died in Paris, Feb. 15th, of a diabetic affection complicated with derangement of the liver, M. Laugier, aged 73. This eminent surgeon has for the last eighteen years occupied the chair of clinical surgery at the Hôtel Dieu.

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This work is so well known to the profession that an extended notice of it would be needless at the present time. The author has made numerous additions and alterations, in such a manner, however, as not to increase the size of the volume —a circumstance which no doubt is thought to add to its value as a text-book. The new articles occur in the discussion of tuberculosis, relapsing fever, and the therapeutic uses of carbolic acid and the hydrate of chloral, and are generally exhaustive treatises of what is known upon the subject.—*Philada. Med. Times*, Jan. 1, 1872.

Although we had to remark on some deficiencies and a few errors, our opinion of the former edition was very favorable. Of this third issue the same good opinion may be expressed, and we are pleased to find the author has taken note of our remarks, and made the corrections and additions we ventured to suggest.—*British and Foreign Medico-Chirurg. Review*, Jan. 1872.

This little volume is already well and favorably known through its former editions, and is generally acknowledged to be the most comprehensive and useful hand-book ever offered to the profession.—*Chicago Med. Examiner*, Dec. 11, 1871.

This book is from one of the ablest men in the profession. We find it to be decidedly one of the essentials in governing and directing students and practitioners in medicine in the road to success, in combating the various diseases of the human family. It is well arranged under proper heads, containing the remedies, so far as science reveals, to the present time. A complete little volume of this kind contains a fund of knowledge unequalled by any similar publication.—*Leavenworth Med. Herald*, Dec. 1871.

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HENRY C. LEA, Philadelphia.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on the Significance of Uterine and Vaginal Discharges. By ROBERT BARNES, M.D., Obstetric Physician to St. Thomas's Hospital, etc. etc.

Discharges of Air.—Air may get into the vagina, if not into the uterus, in the non-pregnant state. In the normal condition the walls of the vagina are maintained in perfect contact, and no air, or probably very little, is admitted. But where the parts are greatly relaxed, the vulva open as when the perineum is torn, the lower part of the vagina is no doubt exposed to the contact of air. But the very condition of patency prevents the retention of the air to such a degree as to lead to its escape in perceptible volume. Air also penetrates where too large a pessary is worn, which keeps the vaginal walls apart. But under peculiar circumstances air enters in large quantity, to be expelled with noise. Dr. George Harley details[1] a curious case in which he carried out decisive experiments to prove the correctness of the diagnosis. A pluripara frequently expelled air from the vagina with a loud noise. It was ascertained that no connection existed between the rectum and vagina. Dr. Harley took a full-sized male catheter, to which was attached a long India-rubber tube with a stopcock at the other end. The catheter was introduced into the uterus, the end of the tube with the stopcock being placed in a tumblerful of water. No air escaped when the instrument was in this position; but, on placing the open end of the catheter in the vagina, an instantaneous discharge of gas took place. The water was found to be sucked up through the tube into the vagina. It was found that the

[1] Obstetrical Transactions, 1863.

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vagina sucked in and expelled the air by spasmodic action. It was further observed that the abdominal muscles assisted in the suction process. The uterus was completely retroverted. This displacement being remedied, and the patient's health improved by tonics, a cure ensued.

If you observe the vagina when the duck-bill speculum is applied, you will see movements of rise and fall under the influence of the rise and fall of the diaphragm. Dr. Adolph Rasch has investigated[1] the phenomena with great care. He says, if a multipara whose genitals are normal be placed on her back, with the thighs flexed and abducted, and the vaginal orifice closed, movements caused by respiration are seen, but no air enters. In the lateral position the same thing is observed even if the vagina is lax, and even when the perineum is ruptured. When the patient is placed in the prone position, or on all-fours, if the vulva be open, air will enter, because the intestines falling downwards by gravity cause a vacuum. Under this condition violent exertion may expel air, giving rise to vaginal flatus. If the abdomen be supported by the hands or by a bandage, no air enters.

There are several interesting applications of this knowledge. It teaches that the best position after labour, if not during labour also, is the dorsal; that the same position is also best in the case of pelvic abscess or hæmatocele discharging into the vagina; and that we must carefully consider this respiratory rise and fall of the vagina when selecting pessaries. It is by turning to account this action that we derive the greatest advantage from the spoon or Sims's speculum. The blade drawing the perineum well back, whilst the semi-prone position of the patient favours the falling forwards of the abdominal viscera, air fills the vagina, counteracts the effect of inspiration, and thus enables us to get a good view of the os uteri. The same position also greatly aids our efforts at reducing inversion of the uterus, and in replacing a prolapsed umbilical cord. In most operations, however, upon the uterus and vagina, where it is of importance to bring the uterus as low down near the vulva as possible, the dorsal position, by bringing the force of gravity to counteract the respiratory rise of the uterus, which can further be greatly aided by direct pressure by an assistant's hand above the symphysis pubis, is the best.

If we were to follow out in detail all the indications supplied by the examination of the discharges, we should be led through almost the entire range of uterine and vaginal pathology. This, in fact, is simply the converse proposition to one already stated—namely, that almost every uterine or vaginal disease is attended by discharge. But to adopt the discharges as our point of departure, from which to proceed to study and classify the diseases of which they are consequences, would be a most intricate course, and not the most orderly or profitable. I will therefore not pursue this method further than to give one instance of how we may apply it to clinical analysis. We will at our next meeting take hemorrhage, and sketch what its purport is.

The Watery Discharges.—When these occur, you must first of all determine the presence or absence of pregnancy. It is no uncommon thing that discharges of water, more or less profuse, take place in pregnant women. This is the hydrorrhœa gravidarum. Gushes of water, quite clear, may occur at almost any time during pregnancy; but they are more frequent in the latter months, and especially in the last month. Happening at this time, they are commonly taken as an indication of commencing labour, and many are the false alarms which patient and doctor have to suffer from this cause. "The waters have broke," says the nurse. You go, as in duty bound, and find probably the os uteri closed, nothing resembling active labour-pains. What are you to do? If you wait for labour, you may wait for a week, or two or three weeks. If, on examination by ballottement, you find the child still floats in the uterus, the os uteri not open, and no active pains, you may go home and wait in peace for another summons.

What is the source and nature of this

[1] Ibid., 1870.

hydrorrhœa gravidarum? Several theories have been expounded. The character of the fluid differs in some respects from that of liquor amnii. It is odourless, and resembles blood-serum, or the serous fluid effused in the peritoneal sac. Ruysch and Rœderer thought it came from ruptures of lymphatic vessels, or of hydatids of the uterus; Böhmer thought it escaped from a second abortive ovum; Delamotte and Cruveilhier that it came from a cyst near the ovum; Deleurye, Puzos, Naegele, and Dubois that it came from the inner surface of the uterus, being secreted externally to the ovum. Dubois says it is the result of loosening of the membranes from the uterus when the vessels pour out serum. Hegar says the source is the uterine glands of the decidua. Thus, he describes[1] the glands of the mucous membrane as being found in the decidua at the sixth month of gestation, and argues that their sudden disappearance in the subsequent months is improbable. In a case of hydrorrhœa he found in the decidua vera, at the beginning of the eighth month, an enormously developed glandular body. At the bottom of this morbid growth was a general hypertrophic condition of the decidua and its glands. These gave out the excessive secretions. In a case related by Dr. Graef,[2] repeated discharges took place, and the fœtus was expelled at the end of six months. The membranes were very delicate, and openings were found in them. In this case, it is probable that the fluid was true liquor amnii. In another case the patient suffered, during the last three months, from repeated watery discharges; the uterus rising and falling with the gathering and escape of the fluid. The membranes were found without rent. Graef regarded this as a case of catarrhal hydrorrhœa.

I believe there are various sources. In some cases the fluid is liquor amnii. This may come either from rupture of the membranes; from rapid transudation under pressure; from rapid formation and accumulation of liquor amnii in the amnion; or from the bursting of a cyst formed between the amnion and chorion, or between two layers of chorion, the proper amniotic sac remaining intact. In the majority of cases, however, the fluid is not amniotic; for when once the amniotic sac has fairly ruptured, labour is not far off. It is, then, the result of a rapid secretion from the uterine glands, or from the cervical cavity. In the early months, whilst there is still a free space between the decidua vera and the decidua reflexa, there is a large area of developed glandular surfaces.

I have observed a *puerperal form of hydrorrhœa.* Thus, watery discharges may continue for a month or longer beyond the proper lochial flow. Generally in these cases the water is dirty, discoloured, occasionally stained with blood, and offensive. The most common cause I have found to be the retention of a portion of placenta, or of clots in the uterus; but a polypus may produce like results. The watery discharges alternate, but not always, with discharges of blood. The fluid may, under certain conditions, collect in considerable quantity in the uterus, so that the organ becomes greatly distended before the collection is expelled in a gush.

Sometimes watery fluid is mingled with air, constituting *physo-hydrometra.* This is also a puerperal or post-puerperal condition, and is commonly the result of retention of some portion of placenta or membranes, and the admission of air into the uterine cavity. If an examination is made when the uterus is relaxed after labour, especially if the hand be introduced into the uterus, the vaginal walls are separated from their usual contact, and a channel is formed along which air easily enters. Merely turning on the side, or a little more prone, will often, by favouring the fall of the uterus forwards, produce a vacuum into which air will rush. This is one reason amongst others why I am unable to approve of the abolition of the old-fashioned binder, which some people would condemn for no better reason that I can see than because it is old-fashioned. After labour, especially in pluriparæ, the abdominal walls are so relaxed that they can give no support to the uterus. The binder does temporary

[1] Monatsschrift für Geburtskunde, 1863.
[2] Jenaische Zeitschrift, 1865.

duty for the inert abdominal walls. The history of physo-hydrometra is, I believe, this: a portion of placenta, membranes, or clots remains in the cavity of the uterus after labour; some air gets in as I have described; decomposition ensues, and the gases of putrefaction are added to the air from without, whilst the os uteri is occluded by the placenta or blood-mass falling over it. When this occurs, there is invariably hectic or irritative fever; peritonitis and septicæmia commonly attend; great abdominal pain; the enlarged, distended uterus can be mapped out rising as high as, or higher than, the umbilicus; and resonance is made out on percussion.

One condition, the result of impregnation, often leads to copious and repeated discharges of watery fluid; the *hydatidiform degeneration of the chorion.* In this case the ordinary signs of pregnancy may not be present, and even the patient herself may not think she is pregnant. There is, however, always evidence of enlargement of the uterus, and generally great pelvic distress. The water escapes in gushes at uncertain times; it is often tinged with blood, resembling red-currant water; it has not the offensive odour belonging to the watery discharges of cancer; sometimes, but not often until late in the progress of the case, cysts will be found swimming in the water; it is generally expelled with painful uterine contractions. In a case we recently had in Adelaide ward, the nature of the disease was not at first suspected. There was some abdominal enlargement, retention of urine requiring the catheter, and most distressing pelvic pain with irritative fever. The os uteri was found high up above the symphysis pubis, whilst behind it the pelvic cavity was filled with a large, rounded, firm mass taken to be either the retroverted gravid womb, or a fibroid tumour. One day a large quantity of water, blood, and a mass of chorion-cysts were expelled. We had, in fact, the condition of retroverted gravid womb complicated with hydatidiform or cystic degeneration of the chorion.

Apart from pregnancy, watery discharges are often of grave significance. During and after the climacteric period, the most frequent cause is some form of malignant disease, especially the so-called cauliflower excrescence of the uterus. In this case other symptoms will probably point to the seat and nature of the disease. The fluid discharged is seldom clear; it is generally turbid, dirty, often tinged with blood, resembling water in which flesh has macerated; it contains shreds or flocculi of solid matter, the proceeds of superficial erosion or necrosis of the surface of the diseased growth, and is almost always of a peculiar offensive odour. It often alternates with hemorrhage. Local exploration will place the nature of the case beyond doubt. Another form of malignant disease giving rise to watery discharges is the "oozing excrescence of the labia."

But we must remember that similar discharges may take place from polypus or inversion of the uterus. Hence we have another example of the wisdom of not pronouncing a diagnosis until we have made an internal examination. Water may escape in large quantity from the rupture or perforation of an ovarian cyst into the vagina. In such a case, the rapid concurrent diminution of the abdominal tumour will lead to the right conclusion. —*Lancet*, Feb. 10, 1872.

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Abstract of a Clinical Lecture on a Case of Spina Bifida cured by Injection. By James Morton, M.D., Surgeon and Clinical Lecturer, Glasgow Royal Infirmary.

John K., æt. 2 months, was admitted into the Glasgow Royal Infirmary Oct. 2, 1871, with a tumour opposite the upper lumbar vertebræ, globular in shape, of about the size of a small orange, and presenting the usual appearances of a case of spina bifida. Its covering was thin, so that it was quite translucent; and at the child's birth it was about half its present size. The mother stated that the tumour felt harder and fuller when the child cried. Moderate pressure upon it did not cause much inconvenience or suffering; and the child had never had convulsions, and seemed in all other respects quite healthy; the fontanelles being neither more open nor more full than usual at the same age.

On October 12th, the tumour was punctured with a grooved needle, and rather more than half of its contents—a pale,

straw-coloured fluid—was removed. It was then covered with lint dipped in oil, and over this cotton-wool; and, to fix the whole and afford a slight pressure, a broad elastic band was passed round the waist of the child. The sac speedily refilled, and on the 18th was punctured a second time; and again it refilled.

On October 24th, the tumour had regained nearly its former size; and to-day it was punctured with a trocar and canula of moderate size. After it had been half emptied, a small portion—probably nearly half a drachm—of the following solution was injected: ℞ Iodi gr. x; potass. iodidi ʒss; glycerinæ ʒj.

On October 26th, the child continued well, having no bad symptoms, and being only a little "fractious." In the swelling, a portion of a soft, solid substance could be felt, rather to one side.

On November 2d, the mother was allowed to take the child home for a day or two; and on the 6th she returned to the Infirmary, when it was evident that some degree of refilling had taken place. The tumour was again injected with a small portion of the same solution. How much actually entered the sac, it was not possible to say. The child, however, continued quite as well as before; and on November 23d he was brought up and shown to the clinical class, when the tumour was found to be smaller and harder than formerly, without any appearance of redistention with fluid.

On December 7th, the child was again shown at the hospital; and now the swelling presented the appearance of a shrivelled bag of skin, darker in colour than the adjacent integument, somewhat resembling a corrugated scrotum, and afforded reason to believe that there was now complete closing of the opening in the spinal membranes. The health of the child was perfect, his mother affirming that he never was so well and comfortable as he was now.

On January 8th, 1872, the child was again brought to the hospital, merely to show that he continued quite well.[1]

[1] This patient was shown to the members of the Medico-Chirurgical Society at the meeting on the 1st February last.

Remarks.—In commenting on this case before the clinical class, a short account was given of the usual appearances presented by such tumours, and the ordinary coverings and contents were noted. Reference was also made to the deficiency in development of the osseous portion of the spinal canal, as the origin of the name, which of itself conveys no idea of the importance of the contents; and remarks were further made to the following effect: It is in reality a local dropsy, consisting of a collection of serum within the serous covering of the spinal cord; and, too often for the safety of the patient, there is also a portion of the nerve-structure of the cord, which has left its proper line, and lies extended under the serous lining of the sac, just under the skin, running, as it were, round or half round the circumference of the swelling, which is often globular, as in this instance. It is this condition chiefly which renders interference with such cases hazardous, and which presents to the mind of the surgeon the possibility of the nervous matter of the cord being so disturbed as to lead to very violent and dangerous manifestations of the effects of irritation of such tissues, in the form of convulsions, which not seldom terminate fatally. Even when left to nature, the rule seems to be, that the subjects of such malformations die, and that early—within the first or second year. To this, it is well known, there are exceptions; still it is the rule. Attempts are usually made by relatives, under professional advice, to protect the part by the use of hollow cup-like shields, lined with cotton, and most carefully attended to; but the result is disappointment, so far as life is concerned. These tumours are far more common in the lumbo-sacral region than in all the other portions of the spine put together; and this is an example of one in the lumbar region.

Treatment.—Allusion has been made to the palliative or protective treatment, as we may venture to call it; and we now turn our attention to the modes of attempting the radical cure, and give shortly our reasons for adopting the plan which has been so fortunate in the present instance. Though it may be true that ac-

tive surgical interference usually hastens death, yet cases have recovered after various kinds of treatment. The presence of the cord, and the free communication with the serous covering of the spine and the brain, are the chief obstacles to success. Inflammation of the cord or its membranes, or gangrene of the cord, causing paralysis, may occur, speedily ending in death. Even when left untouched, the skin often ulcerates, the sac bursts, and palsy or convulsions cause death. A spontaneous cure has been known to take place, the orifice of communication having closed, the tumour becoming a closed cyst, and remaining innocuous, or it may be removed. Rupture of the sac has even been followed by recovery. Three modes of interference present themselves—injection, ligature, and excision; and of these three modes, it may be said that each of them has been effected by a variety of means and appliances, which it is not my purpose to enumerate at present. Suffice it to say, that I resolved to adopt the first of these, as, in my opinion, the least dangerous of the three. It will be noticed that twice I punctured the sac with a grooved needle, and drew off a considerable quantity of the fluid. These may be called tentative measures, to ascertain whether the membranes could be pierced with safety; and, no suffering or derangement of function having followed, I felt encouraged to use an iodine solution. In forming this solution, I resolved to use glycerine as the solvent; for the reason that it is a fluid of less diffusibility than a spirituous or even a watery solution. Not that I for a moment imagine that it could not be conveyed along the serous cavity or the serous lining of the spine; still, to my mind, it offered one element of greater security. The strength of the solution may be noted; but then it must be observed that, in using it, the sac was purposely only half emptied of its serum when the iodine solution was injected; and of the latter only about half a drachm was actually injected, so that the then ioduretted contents of the sac presented a very dilute solution. When the repetition of the injection was made, somewhat more of the iodine fluid was used; but part of it escaped and was lost, so that, as the report states, it was not possible to estimate correctly the amount retained. A degree of solidification followed the first injection; and after the second it became complete, and now remains so, the part admitting of ordinary handling without inconvenience or discomfort to the child.

A line of treatment very similar to this has been followed by several of the American surgeons, and with instances of success; but statements are discordant in regard to the proportion which the successes bear to the failures. Several British surgeons have also operated successfully in a limited number of cases and by various methods, but most frequently by injection with iodine as the coagulating or stimulating agent; but I am not aware of glycerine having been used as a solvent on any previous occasion, and I may indulge the hope that others may be induced to try it.

From what I have seen of such cases, it is my belief that the fluid should not be allowed to drain completely from the sac: this leads to fatal results; and, where a puncture has been made, the aperture, however minute, may be closed and guarded by a layer or layers of collodion, especially when subsequent oozing is feared or perceived.—*Brit. Med. Journ.*, April 6, 1872.

HOSPITAL NOTES AND GLEANINGS.

On the Value of Observations of the State of the Pupils in the Diagnosis of the Position or Nature of the Lesions in Acute Cases of Cerebral Disease. By Huhlings Jackson, M.D.—In cases of apoplexy, the pupils are always examined; but they are sometimes put down as being "contracted" or "dilated" without due consideration. In some cases of fatal apoplexy from cerebral hemorrhage, the pupils cannot be said to be altered in size, for there is nothing remarkable about their size. The pupils differ in size in different people and at different ages; and thus it occasionally happens that, when a patient is apoplectic, we are really not warranted in saying that they are larger or smaller than they were before the attack. It is better, in these cases, to use the words large or small, than the technical terms which imply that

there is an alteration in size from the recent cerebral lesion. *Extreme* contraction of both pupils is, when there is also universal powerless and deep coma, evidence of large hemorrhage in the pons Varolii; but, as this condition of the pupils is found in cases of poisoning by opium (from which also there result coma and universal powerlessness), the diagnosis betwixt these two forms of apoplexy is sometimes impossible. When the patient is found comatose, there being no history to show in what way his illness set in, we cannot make a diagnosis, unless, for instance, we find an emptied laudanum bottle. On the other hand, it is quite certain that, in some cases of large hemorrhage into other parts of the encephalon, there is extreme contraction of the pupils. Again, in a few cases of fatal hemorrhage into the pons, the pupils are not minutely contracted. In cases of apoplexy, either from cerebral hemorrhage or from poisoning by opium, contracted pupils will dilate shortly before death.

Two observers may come to different conclusions as to the size of the pupils in the same case of apoplexy, if they observe them when the patient is in different conditions. It often happens that the pupils of a comatose patient are very small—as small as they are in healthy sleep—whilst he lies undisturbed; but, when he has been aroused by examinations of his limbs, or by pinching or shaking, the pupils will become much larger, presumably of their normal size. This is so when the patient can be only roused to vague movements of fretful resistance, and not to anything like real consciousness. Unless these facts be borne in mind, we may err in supposing there to be remarkable variations in the size of the pupils during the course of a case of apoplexy.

Inequality of the pupils is of more value in diagnosis, but not unless the pupils be of *very* different sizes. If, in a case of injury to the head, one pupil be very large, there is probably, Mr. Hutchinson says, large effusion of blood in the sphenoidal fossa of the side of the dilatation. Great contraction of one pupil occurs from lesion of the same side of the pons Varolii, but not always. No doubt the precise seat of the lesion makes a difference. In a case of inequality of the pupils, observed in a patient who died apoplectic from injuries to the head, the cause of inequality was seen, on instillation of atropia, to be the existence of iritic adhesions. Oddly enough, a confident prediction as to the side on which the cerebral lesion would be discovered at the necropsy (founded on the difference in the size of the pupils), turned out to be correct. In another case, contraction of the pupil, put down to some affection of the cervical sympathetic, was thus explained away.

In most cases of *severe* convulsion, whatever the cause of seizure may be, the pupils dilate very widely during the paroxysm. In one case of convulsion with extensive intracranial hemorrhage, the pupils became very wide, so that Dr. Hughlings Jackson was able to see the optic disk by the aid of the ophthalmoscope. When the convulsion had passed off, the pupils were so small that the disks could not be seen until after the use of atropia.

On the whole, observations on the state of the pupils are not as yet proved to be of much value in the diagnosis either of the position or of the nature of lesions in acute cases of cerebral disease.—*Brit. Med. Journ.*, April 6, 1872.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

American Medical Association.—As we have already announced, the annual meeting of this Association will be held at Horticultural Hall, Broad Street below Locust, in the city of Philadelphia, on Tuesday, May 7, 1872, at 11 o'clock A.M.

The Secretary will be in attendance at the Horticultural Hall on Monday, May 6th, and all duly accredited delegates who may be in the city on that day are requested to present themselves for registration.

The annual exhibition, which is to be held in the Hall of the College of Physicians, N. E. corner of Locust and Thirteenth Streets, will be open daily throughout the week, commencing Monday, May 6th.

The Municipal Hospital of Philadelphia.—The report for 1871, of Dr. WILLIAM M. WELCH, Physician in Charge of the Municipal Hospital, contains a number of facts in reference to the admission and treatment of patients in that institution. The hospital ordinarily has a capacity for 190 beds, but in consequence of the prevalence of the smallpox, temporary improvements were made so as to accommodate 312, the highest number under treatment at any one time. During the past year 1227 patients with variolous diseases and 22 with other diseases were admitted, of which 677 were variola (smallpox) cases, and 550 varioloid; of the former 353, or 52.14 per cent., died; and of the latter only 8, or 1.45 per cent., died. The ages of those admitted were as follows:—

Ages.	Admitted.	Died.	Per cent. of Deaths.
Under 1 year	12	10	83 33
1 to 15 years	162	60	37.00
15 to 25 years	599	185	30.88
25 to 45 years	383	108	28.19
45 years and upwards .	71	24	33.8
Total	1227	387	31.54

In making a differential diagnosis between the two varieties of the disease, Dr. Welch paid no regard as to whether his patients had or had not been vaccinated, except to classify all unvaccinated cases, no matter how mild, as variola. He classified all cases as varioloid where the patients had been vaccinated. In all the deaths from varioloid (or vaccinated cases) there has been either some constitutional peculiarity, or some intercurrent disease that has been auxiliary in terminating life. In reference to vaccination, the doctor states that variola, or smallpox, in unvaccinated infants, is almost uniformly fatal, and that vaccination performed less than seven days prior to the appearance of the eruption will not modify the disease; but when performed as long as seven or eight days prior, it may so far modify the disease as to render it harmless. The following table shows the number of patients vaccinated and not vaccinated, number of deaths and percentage of deaths among "good" and imperfect vaccinations:—

	Admitted.	Died.	Per cent of Deaths.
Vaccinated:			
Good Cicatrix . . .	332	33	9.93
Fair Cicatrix . . .	166	27	16.26
Poor Cicatrix . . .	301	68	22.59
Total vaccinated .	799	128	16.
Not vaccinated . . .	390	254	65.12

Dr. Welch classifies as "good cicatrices" all those with a well defined margin, slightly excavated, and pitted or honeycombed, as they are sometimes aptly described, while those presenting these characteristics to a much less degree he classified "fair," and those as "poor" which are so indistinct as to make it difficult to recognize them as vaccine scars. The proportion of deaths among the unvaccinated is enormous—double the ordinary death-rate, which has long been regarded as 33 per cent. Two reasons are assigned for this large mortality: the first and chief being the virulence of the epidemic; the second, that in many instances only the graver cases are sent to the hospital, and many of these not until all hope of recovery is passed.

The above statistics show, conclusively, the great protective powers of a proper vaccination against the mortality from smallpox.

—

Mortality in Philadelphia from Smallpox.

Week ending March 30	80
" " April 6	74
" " " 13	71
" " " 20	62

The above table shows that the epidemic is steadily decreasing, the mortality having diminished from 233 in the week ending December 2, to 62 in the week ending April 20.

—

Medical Graduates in 1872 (continued from page 57).—

University of Nashville . . .	84
Chicago Medical College . .	32
Geneva Medical College (N. Y.) .	12
Missouri Medical College . .	40
St. Louis Medical College . .	68
University of Louisiana . . .	58
Washington University (Baltimore, Md.)	57
University of Iowa . . .	16
Indiana Medical College . . .	20

Philadelphia College of Pharmacy.—At the fifty-first annual commencement of this school, on the 15th of March last, the degree of Graduate in Pharmacy was conferred on 59 candidates.

—

Jefferson Medical College.—We have the pleasure of announcing the election, on the 26th of April, of Dr. J. M. DaCosta to the chair of Practice of Medicine in Jefferson Medical College. The acquisition of the services of so eminent a teacher must redound to the advantage of the school, and tend to maintain the high reputation which Philadelphia has so long enjoyed as a centre of medical instruction.

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Bellevue Hospital Medical College.—The following changes have taken place in the Faculty of this College: Prof. B. W. McCready having resigned, Prof. W. A. Hammond will assume the chair of Materia Medica and Therapeutics, and Clinical Medicine, in addition to that of Diseases of the Mind and Nervous System. On the latter branches he will continue his lectures and clinics as heretofore. In consequence of the resignation of Prof. Stephen Smith, Dr. A. B. Crosby has been appointed Professor of Descriptive and Surgical Anatomy. Dr. E. G. Janeway has been made Professor of Pathological Anatomy, and will lecture on that subject in the regular session, while, as Professor of Practical Anatomy, he will act as Demonstrator in place of Dr. Mosely. Prof. Mott relinquishes Surgical Anatomy to the chair of Anatomy, but will hold his Surgical Clinic at the College on Wednesdays throughout the year. A new outdoor medical clinic has been established under charge of Prof. Flint; and a new clinic for Diseases of Children, under charge of Prof. Lusk. Dr. E. L. Keyes has been appointed Prof. of Dermatology. —*New York Med. Journ.*, April, 1872.

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Obituary Record.—It is with deep regret that we record the death, on the 5th of April, at the mature age of 85, of our highly esteemed and nearly life-long friend, Samuel Jackson, M.D., Emeritus Professor of the Institutes of Medicine in the University of Pennsylvania.

It would require a more eloquent pen than our own to do justice to the eminent merits of Dr. Jackson — to his brilliant genius—his great scientific attainments—his enthusiastic pursuit of knowledge, which kept him constantly in advance of his cotemporaries — his eloquence as a lecturer, which inspired his hearers with much of his own zeal for investigation and for elucidating by observations and experiments the still obscure points in physiology — his remarkable conversational powers—his genial social qualities—his scrupulous integrity, and his kind, liberal, and generous disposition.

The Medical Faculty of the University of Pennsylvania have adopted the following resolutions expressive of their regret at the loss of their colleague, and of their respect for his memory:—

"1. *Resolved*, That the announcement of the death of their venerable colleague, Dr. Samuel Jackson, Emeritus Professor of the Institutes of Medicine, has deeply impressed the Medical Faculty of the University, and quickened the feelings of affectionate respect which they have always entertained for his person and character.

"2. *Resolved*, That to his genius in cultivating medical science, his eloquence in expounding its laws, and his earnestness in enforcing its precepts, the Medical Department of the University is deeply indebted for the fame it enjoyed and the influence it exerted during the long period of his professorship.

"3. *Resolved*, That his ardent temperament, genial disposition, and enthusiastic love of knowledge inspired all who knew him as associate or teacher with an ambition to follow in his footsteps, and adorn, as he adorned, the profession which he ennobled by his character and illustrated by his life-long labours.

"4. *Resolved*, That the Faculty will preserve the memory of Dr. Jackson's character and services as a model for the young to imitate, and a monument to be admired by all who reverence genius, and its practical results in enlarging the field of knowledge and in mitigating the pains and perils of disease."

R. E. Rogers, M.D.,
Dean of the Medical Faculty.

April 8, 1872.

We are also pained to record the death in this city, on the 31st of March last, aged seventy-four, of SAMUEL HENRY DICKSON, M.D., Professor of the Theory and Practice of Medicine in Jefferson Medical College, Philadelphia. Dr. D. was a highly cultivated, honourable, and urbane gentleman, and one of the bright ornaments of our profession. He filled successively the chair of Practice of Medicine in the Medical College of the State of South Carolina, in the University of the City of New York, and in Jefferson Medical College, and with great credit to himself and advantage to numerous pupils.

At a special meeting of the Faculty of the Jefferson Medical College, convened in reference to the death of their late esteemed colleague, it was—

"*Resolved*, That the members of the Faculty have heard with deep-felt sorrow of the demise of their late distinguished colleague, Samuel Henry Dickson, M.D., LL.D., Professor of the Theory and Practice of Medicine, whose name and fame for the last fourteen years have been connected with this Institution, and for half a century with medical teaching. Ripe in years, and rich in all the honours that could be gathered from the broad fields of science and literature, he has closed a long and active life, made, by his genius and vast experience, most eminently useful in ministering to the relief of the sick, and in the education of a very large portion of the medical profession of this country. A courteous gentleman, a genial and refined associate, always amiable and instructive in his intercourse with his fellows—wise, learned, and accomplished as a teacher—the Faculty of this College and the profession at large may well sorrow over the extinction of a life so rich in usefulness and renown.

"*Resolved*, That the Faculty, in remembrance of his many virtues, and in profound respect to his memory, will pay their last tribute to a loved colleague by attendance at his funeral; and further,

"That a copy of these resolutions be transmitted to his family."

B. HOWARD RAND, M.D.,
Dean of the Faculty.

At a memorial meeting of the Medical Society of South Carolina and of the Medical Profession generally, held April 11th, at the Roper Hospital, Charleston, several very eloquent and pertinent addresses eulogistic of the character of Prof. Dickson were delivered, and the following resolutions were adopted:—

"*Resolved*, That, in the recent death of Professor Samuel Henry Dickson, our associate, our colleague, and long-endeared friend, this society and our professional brethren at large have sustained a loss which they will deplore with deep and heartfelt grief.

"*Resolved*, That, by this afflictive dispensation, the science of medicine has been deprived of one of her most honourable votaries, the college in which he recently served with such distinguished success a most estimable colleague, society a refined and cultivated ornament, and humanity one who ever felt for the afflicted, and practised a wide-spread benevolence in his efforts to mitigate the afflictions and sorrows of mankind."

Died in Richmond, Va., March 26, 1872, aged 70 years, ROBERT W. HAXALL, M.D. Dr. H. was an accomplished, skilful, and highly-esteemed physician, and a high-minded and honourable gentleman. He was one of the active founders of the American Medical Association, and was chairman of the committee appointed to report a uniform and more elevated standard of requirements for the degree of M.D., to be adopted by all the medical schools of the United States, and which report met the approval of the Association.

—— At Detroit, Michigan, April 5th, aged 85, ZINA PITCHER, M.D. Dr. P. was one of the pioneers of the Northwest, and had many offices bestowed upon him, which he ably filled. In 1822 he was appointed an assistant surgeon U.S.A., and afterwards full surgeon, which post he held until 1836, when he became a citizen of Michigan, and exerted a most beneficial influence in the establishment of the educational institutions of that State. He was appointed Regent of the University, and was mainly instrumental in organizing its Medical Department. He was an active member of the American Medical As-

sociation, and was elected president of that body in 1856.

—— March 15, 1872, at San Francisco, California, JONATHAN LETTERMAN, M.D., formerly Medical Director of the Army of the Potomac, in which position he displayed remarkable executive ability and energy, establishing a new and very perfect ambulance system, a method of field-purveying, and a plan of field-hospitals.

—

Presbyterian Hospital of Philadelphia.—In the list of the staff of this hospital given in the April number of the *News*, the name of Dr. Edward Wallace should have appeared as one of the physicians, instead of that of Dr. Ellerslie Wallace, who was not a candidate for the position.

FOREIGN INTELLIGENCE.

Fibroid Tumours of the Uterus.—M. GUÉNIOT has communicated to the Academy of Medicine (*Med. Times and Gaz.*, March 23, 1872) an example of that rare occurrence, the disappearance of an uterine fibroma by absorption. In his opinion, founded on M. C. Bernard's experiments on the pancreas, when a fibroma or myoma thus disappears it first undergoes fatty degeneration; and, therefore, those agents should be employed in their treatment which tend to produce fatty transformation of the tissues or organs. The principal of these are arsenic, phosphorus, and lead; and it is to such medicinal substances recourse should be had much rather than to mercury, iodine, bromine, and the alkalies. The following are his conclusions: 1. The cure by absorption of certain fibroid tumours of the uterus, still sometimes disputed, may henceforth be regarded as a truth definitively proved. 2. These tumours may even undergo a rapid dissolution, some months sufficing in various cases for the complete disappearance of even large myomas. 3. In the cases hitherto observed, absorption has taken place during the period of activity of the genital affections; but the puerperal state has only quite exceptionally exercised an evident influence. 4. Uterine myoma may also disappear without surgical operation by two other modes, viz., spontaneous expulsion, and gangrenous destruction or suppuration. But its disappearance by absorption, being the only mode completely exempt from danger and followed by cure, is that which should especially be sought to be induced. 5. Although the attempts made in this direction have almost constantly been unsuccessful or dubious in their results, some facts authorize us to believe that treatment is on the road of progress. 6. As far as can be judged by analogy, an uterine myoma, in order to become susceptible of absorption, must first undergo a fatty transformation of its mass. 7. The employment of steatogenic substances, such as arsenic, phosphorus, lead, etc., seems especially indicated in view of this result.

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Spina Bifida cured by repeated Tapping and Pressure.—At the meeting of the Lisbon Society of Medical Sciences on February 17th (*O Correio Medico de Lisboa*, March 1st, 1872), Dr. Camara Cabral communicated a case of congenital spina bifida which he had successfully treated. The patient was a child aged twenty-five days, which was brought into St. Joseph Hospital on November 21st. It had in the lumbo-sacral region a swelling 40 centimetres in circumference, 17 in vertical and 10 in transverse diameter, and 6 in depth. It fluctuated, was transparent like a hydrocele, and appeared to contain not only fluid but some solid body. Pressure on it did not produce any convulsions, nor were there any paralysis or other symptoms denoting lesion of the spinal cord. It was, therefore, concluded that the tumour consisted exclusively of a hernia of the meninges, filled with fluid. On the 29th, it was tapped with a Dieulafoy's trocar, and 400 *grammes* of a transparent yellow fluid, containing an abundance of albumen, were removed. Compression was applied by means of adhesive plaster. No symptoms followed the operation, beyond some vomiting and loss of appetite. Some days later, the tumour having again enlarged, 250 *grammes* of liquid were removed; and on December 14, 425 *grammes*. The defect, which was found to be in the situation of the fourth and fifth

lumbar vertebræ, was gradually diminishing. On a fourth and a fifth occasion, puncture was performed at intervals of some days; the quantities evacuated being respectively 175 and 125 *grammes*, and the fluid being more highly albuminous than before. After the last two operations, there was some meningitis, which yielded to ordinary remedies. The child made a good recovery, and was exhibited at the meeting at which the case was described.--*Brit. Med. Journ.*, Mar. 23, 1872.

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On the Surgical Treatment of Suppurating Ovarian Cysts and on Pelvic Adhesions in Ovariotomy.—Mr. T. Holmes reported to the Royal Medical and Chirurgical Society a case in which chronic suppuration occurred in an ovarian tumour, after paracentesis had been performed for the first time. Ovariotomy was postponed for some months on account of the patient's condition. When it was performed the cyst was found extensively adherent in other directions, and so tightly wedged into the pelvis that it was impossible to reach its pedicle. It contained about a gallon and a half of fluid, of which about half was pure pus. The remains of the emptied cyst was dragged out of the abdomen, a clamp was applied to its neck (at a distance above the pedicle which could not be accurately ascertained), and the wound was closed. The patient recovered, and after her recovery no sinus was left, nor was any tumour to be felt. The symptoms of acute and chronic suppuration in ovarian cysts are discussed, and it is attempted to be shown that, if the general condition admits of it, the suspicion of suppuration is a reason for performing the operation instead of delaying it. The case is also used to show that, in some instances, the results of ovariotomy may be perfectly favourable, though pelvic adhesions have prevented the complete delivery of the tumour. If the neck of the cyst admits of being embraced in a clamp, the lower portion of it may be obliterated during the healing of the wound. The superiority of this method, when feasible, to the other courses which may be pursued in dealing with pelvic adhesions, is shown.

Mr. Bryant remarked that the accurate diagnosis of a suppurating ovarian cyst was most important; that wasting, a hot skin, a permanently high temperature, bad appetite, local pain and tenderness on pressure, all indicated suppuration. If any doubt as to the diagnosis exists, he would be still more induced to interfere quickly, to remove the cyst if possible, or to take away as much as could be removed. He quoted a case to show the desirability of not leaving ligatures, and one also that showed the useful peculiarities of catgut.

Mr. Spencer Wells said that the diagnosis between an inflamed or suppurating ovarian cyst and peritonitis was generally easy, the chief point being that with a suppurating cyst there was considerable elevation in the temperature of the body, especially at night. In the morning it would range from 99° to 101°, and in the evening rise to 103° or 105°. In peritonitis, on the contrary--unless it were of the septic type—there was either no rise of temperature, or it might even fall to about 97°. But practice would be the same in either case. Whether the patient's life is in danger from a suppurating cyst, or from peritonitis set up by the presence of the cyst, or from escape of ovarian fluid into the peritoneal cavity, the cyst and fluid should be removed. He had learned this lesson from Sir Thomas Watson. Operating with Dr. Farre on a lady whose peritoneum was acutely inflamed from the bursting of an ovarian cyst, they were very fearful of an aggravation of the peritonitis; but Sir Thomas Watson, with the rare clinical sagacity which was his great characteristic, said, "Now the irritating cause is removed, we may hope the irritation will subside." And it did so in this case and in several others since. In one step of the operation he thought Mr. Holmes might have adopted a safer plan than separating the adhesions before emptying the cyst. These adhesions prevented any purulent or fetid fluid in the cyst from entering the peritoneal cavity, and in most cases it was generally better to completely empty the cyst before separating any adhesions. In cases where the cyst could not be removed a cure might sometimes be obtained by draining the cyst through

a tube and daily injections of iodine or carbolic acid.

Mr. Holmes, in replying, doubted if the diagnostic signs spoken of by Dr. Wells were positive as well as negative, because in some cases high temperature exists without suppuration, and in some cases of peritonitis the temperature has been persistently high.—*Med. Times and Gaz.*, Mar. 30, 1872.

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Combination of Injection of Morphia with Inhalation of Chloroform.—MM. Labbé and Guyon recently read a paper at the Académie des Sciences, in which they gave an account of the results obtained in four cases in which they had tried the combined effect of hypodermic injection of morphia and the inhalation of chloroform. They were induced to enter on the investigation by having observed numerous experiments of M. Claude Bernard at the College de France, which demonstrated that, by such combination, very complete anæsthesia may be obtained by means of a much less quantity of chloroform than when this substance is employed alone. About the same time that M. Bernard was pursuing these researches, Professor Nussbaum, of Munich, with a view to the prevention of the pain consecutive to operations, injected in several cases the acetate of morphia, while the patient was under the influence of chloroform. In all his cases, pain continued suppressed, and sound sleep was prolonged for several hours after the operation.

While Professor Nussbaum, however, employed the morphia during the anæsthesia, MM. Labbé and Guyon injected it before this was produced, their object being also different—not the prevention of consecutive pain, but facilitating the production of anæsthesia, and rendering it less dangerous by reason of the smaller quantity of chloroform employed. At present they have only resorted to the means in the four cases, abstracts of which they now lay before the Academy. In the first of these, twenty minutes before the performance of an amputation, two centigrammes of muriate of morphia were injected into the thigh, and then chloroform was administered. In seven minutes anæsthesia was complete, and was prolonged for a long time after the operation, which lasted seventeen minutes. The quantity of chloroform employed was twenty-eight grammes. In a case of ovariotomy, occurring in a girl of 20, the chloroform was given twenty minutes after the injection, and complete anæsthesia was produced in six minutes. The operation lasted an hour and forty-five minutes, and the expenditure of chloroform during all this time was only forty-eight grammes. The patient continued in a state of complete resolution, and after the operation was entirely calm, having felt no pain whatever. Incomplete as are their researches at present, the authors feel entitled to conclude: first, we can in man—as M. Claude Bernard has shown can be done in animals—obtain anæsthesia much more rapidly by combining the action of chloroform and morphia; secondly, that this anæsthesia is of longer duration, and may be kept up by smaller doses of chloroform, the risks of fatal accidents being thereby considerably diminished. They suggest also that the quantity of morphia injected may be somewhat larger than that which they employed, and that the injection might be conveniently practised a longer time before the operation.—*Med. Times and Gaz.*, March 23, 1872.

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Death from Chloroform.—In the number of the *British Med. Journal* for April 6, 1872, there is reported a case of this occurring in a man to whom two and a half drachms of chloroform was administered, prior to an operation for iridectomy. Death occurred four minutes after the inhalation began. His heart was found to be fatty.

In the *British Medical Journal* for March 9, 1872, is reported another case of this which occurred at West Middlesex. A medical student aged 22 went to bed apparently well, and in the morning was found dead with a handerchief applied to his mouth. He had been in the habit of inhaling chloroform to allay pain, and a verdict was given to the effect that death had resulted from this cause.

Liebreich's Chloride of Æthyl. — This substance was used instead of chloroform in Langenbeck's wards in 1870, and with the best results. It gave rise to no vomiting; sleep was induced easily, but was less profound than with chloroform. Of course it was expected that the latter would soon be superseded, and that the chloride would prove quite innocuous; but a death under its influence, which lately occurred, proved that absolute safety in the use of anæsthetics has not as yet been obtained.—*Lancet*, March 16, 1872.

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Use of Nux Vomica in certain Neuroses of Organic Life.—M. Brugnoli (*Lyon Méd. et Journ. de Méd.*, Nov. 1871) has employed nux vomica successfully in the nervous movements of pregnancy, gastralgia, dyspepsia, hypochondriasis, nervous palpitations of the heart, nervous and periodic cough, asthma, and finally in albuminuria. This remedy acts either on the pneumogastric, or on the great sympathetic, or on the spinal cord. He records the case of a lady, afflicted with severe cough recurring every evening and lasting throughout the night, who was cured in two days by the use of nux vomica. Another patient was affected every evening with violent cough accompanied by catarrhal expectoration, and was also cured in two days by the use of the alcoholic extract of nux vomica mixed with the extract of gentian. Cough may always be allayed by this means, whether it be caused by bronchitis, by pneumonia, by pulmonary phthisis, or by emphysema. It proves a useful remedy also in cases of cardiac pulsations, and in irregular or too frequent action of the heart. In albuminuria, M. Brugnoli thinks the administration of nux vomica has retarded its progress to some extent, especially in cases of scarlatinal albuminuria.—*Practitioner*, Feb. 1872.

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Chloral in Traumatic Tetanus.—Dr. Lavo relates (*Annali Universali di Med.*, Feb.) three cases of severe traumatic tetanus which were successfully treated by means of chloral aided by the employment of the cold bath. The quantity of chloral used during the course of the first case amounted to 240 grammes, with twenty-five baths; in the second to 147 grammes, with fifteen baths; and in the third to 140 grammes, with eleven baths.—*Med. Times and Gaz.*, March 30, 1872.

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The Removal of Plaster of Paris Bandages.—Dr. Carstens gives a concise way of overcoming the obstacles presented by the plaster of Paris in the application of bandages. It should be good and freshly burnt. By mixing the plaster with cold water, or a solution of gum arabic, a paste is formed which will harden slowly; a quickly hardening paste can be made with a solution of sulphate of potassa or water-glass.

In reference to the removal of plaster of Paris bandages, Dr. Carstens remarks that this application is very insoluble in water (1 part in 438); in concentrated solutions of chloride of sodium, however, it is quite soluble (1 part in 122). Common salt has not only the advantage of being always on hand, but it does not injure polished instruments, as other solutions recommended for this purpose do; if a plaster of Paris bandage is moistened with a saturated solution of salt, the bandage becomes in a few minutes so yielding that a sharp knife finds little resistance; in the cut some more of the mixture should applied, and, after repeating this three or four times, the bandage can be easily removed.

To clean the hand and nails of the operator, table-salt solution is also very useful.—*Medical Record*, Feb. 15, 1872.

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Air in the Veins.—Mr. Trélat related (*British Med. Journal*, March 16, 1872) at a meeting of the Société de Chirurgie of Paris on Feb. 21st, an important case in which sudden death occurred in a patient from whom he was proceeding to remove a submaxillary tumour. The patient changed colour, and the heart-sounds ceased suddenly. Artificial respiration and electrization of the phrenic nerve induced some respirations and a slight return of colour after fifteen minutes, but ineffectually. At the necropsy, a small vein, opening into the external jugular, was found to have been partially divided; in the jugular was a long clot, segmented

by air-blebs, and other bubbles of air were found in one of the mediastinal veins and the posterior cardiac vein, and a very notable quantity of air in the right cardiac cavities. The question raised was, whether the death was due to this cause or to the action of the chloroform. M. Perrin and M. Marc Sée attributed the death to chloroform; and M. Giraldès believed that the entrance of air in the veins acted with the chloroform in producing the fatal result. He stated that, in three cases of death from chloroform, he had found gases in the heart, in the vena cava, and even in the veins of the pelvis. Roux had made a similar observation. But M. Depaul pointed out that the air in this case occupied only the veins going to the heart, and the wounded vein. M. Perrin and M. Depaul were much in favour of artificial respiration by a tracheal catheter and bellows.

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Large Biliary Calculus.—Dr. Thorowgood exhibited to the Pathological Society of London (*British Med. Journ.*, Feb. 24, 1872) a very large biliary calculus, two and three-quarter inches in length, and weighing five hundred and three grains, which was taken from the body of a female aged 67. It was interesting from its large size, and from its having produced no symptoms up to the woman's death.

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Modification of the ordinary Test for the Biliary Acids.—M. Strassburg, of Bremen, suggests (*Pflüger's Archiv für gesammte Phys.*, Heft x. and xi. 1871) a modification of Pettenkofer's test for the presence of the biliary acids in urine, which promises to be serviceable clinically, and according to his statements is of extreme delicacy, enabling a trace not exceeding 3-100,000ths to be readily detected. He dips a slip of filtering paper into the urine suspected to contain the biliary acids, and to which a little cane-sugar has been previously added. The slip is withdrawn and dried; a drop or two of pure concentrated sulphuric acid is now applied to it by means of a glass rod. On holding the paper up to a strong light, a beautiful violet colour makes its appearance.—*Practitioner*, Feb. 1872.

Toxicological Notes.—It is stated in the *Chemical News* that Dr. James St. Clair Gray, assistant to the Professor of Medical Jurisprudence in the University of Glasgow, has read a paper to the Chemical Section of the Glasgow Philosophical Society, "On Certain Fallacies in the Means of Detecting some Poisons." He pointed out that Reinsch's test for arsenic is liable to fail when the arsenic has undergone oxidation to arsenic acid, or when it exists in the state of sulphuret. He advises the reduction of the arsenic acid by means of sulphite of an alkali; and in the instance of the sulphuret, he would boil with caustic potash and dialyse. He notes also that the presence of alcohol, chloroform, or ether, prevents the precipitation of the red iodide of mercury.—*British Med. Journal*, March 16, 1872.

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Vivisections.—M. Claude Bernard, one of the greatest of living physiologists, in his recent work (*Leçons de Pathologie experimentale*) points out the immense value of experimental pathological researches, and the necessity for the construction of special physiological laboratories (like those of Kühne at Amsterdam, and Ludwig at Leipzig) wherever physiology is taught, in order that theory and practice may go hand in hand. Referring to the absurd scruples of the antivivisectionists, he points out the necessity that exists for the daily slaughter of a large number of the lower animals, and gives the following anecdote in a note: "In one of his campaigns the Duke of Burgundy, son of the Grand Dauphin, wrote to Fénélon to ask whether he might encamp his army under the walls of a nunnery, as, however objectionable in point of morality, the position was peculiarly advantageous for the prosecution of the war. Fénélon promptly replied, 'Burn the nunnery, but gain the battle.' Now, Fénélon was certainly not a man of lax morals, nor a man of anti-christian spirit, nor a violent character; but he recognized that war has its necessities, which must be obeyed if success is to be obtained. Physiology, too, has its necessities, and these must be submitted to, or all progress must be renounced.—*Lancet*, March 30, 1872.

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After an examination of this book, we think we are not mistaken in welcoming its writer as a new authority in medical literature on the diseases of children. The sources of his information are copious, and he seems to have made careful use of them. We had intended to support these opinions by quotations, but the range of the work is so comprehensive, and our readers can so much better form a notion of the industry and good judgment of its author by an extended perusal of it, that we have concluded to simply refer them to the book itself, and will only add that it is written in the clear and unambitious style befitting a scientific work.—*St. Louis Med. and Surg. Journal*, May 10, 1869.

Our fellow-townsman, Dr. Smith, is well known among us as an indefatigable worker, and one who has devoted the major part of his time to the study, theoretically and practically, at the bedside and in the dead-house, of the diseases of children. From a careful perusal of his work we agree with the author, that while he has respected the opinions of previous writers, and has adopted them so far as they appeared to be correct, he has depended much more for the material of his treatise on clinical observation and the inspection of the cadaver. Most heartily do we wish the work the success it so richly deserves.—*Am. Journ. of Obstetrics*, &c., May, 1869.

The author of this volume is well known as a valued contributor to the literature of his specialty. The faithful manner in which he has worked in the public institutions with which he has been connected, the conscientious regard for truth which has for years characterized all his researches, the great amount of experience which he has been enabled to acquire in the treatment of infantile diseases, and the care which he has accustomed himself to take in the study of the significant facts relating to the pathological anatomy of the diseases of childhood, eminently fit him for the task which he has taken upon himself. The remarkable faculty of bringing out salient points and stating concisely other less important facts, enables him to crowd within a small compass a vast amount of practical information. The attention given to the treatment of the various maladies, as well as the presentation of all the recently accepted pathological views, make it one of the most valuable treatises, within its present compass, that can be placed in the hands of any seeker after truth. The volume as a whole will still further establish for the writer a permanent and enviable reputation as a careful observer, an impartial interpreter, a safe and trustworthy adviser, and a modest and untiring student.—*N. Y. Med. Record*, March 15, 1869.

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CLINICAL LECTURES.

Clinical Lecture on Infantile Paralysis and its resulting Deformities. By RICHARD BARWELL, F.R.C.S., Surgeon to Charing-Cross Hospital. Lecture II. (For first lecture, see No. for April last.)

Gentlemen: A malady which has received the name of the "temporary paralysis of Kennedy" places the immediate treatment of the disease we are considering in a most unenviable position; while, on the other hand, a belief in the frequency of such transient paralysis often prevents any clear and decisive action for days, perhaps weeks, after the first attack. It is a very thankless task to treat a paralyzed child with all care, and then, when the patient recovers, to feel that it may have been one of those cases which would have done well without our aid. Nevertheless, this is far better than, believing in the temporary nature of the disease, to temporize, to delay still a little longer, and at last to find the limb wasting, and to discover that by loss of time we have also lost, or all but lost, the chance of regaining a useful limb.

My conviction, taken from a large number of cases, is, that the temporary paralysis is very rare, the true infantile (non-central) paralysis only a too common disease. The distinction in the first few hours is impossible, but in from twelve to thirty-six hours it becomes clear and indisputable. When, therefore, first called to a paralyzed child, it is necessary to ascertain all concomitant and pre-existent circumstances. If there be or have been no illness, no prolonged or severe fits, no thermometric elevation either general or merely cephalic, nor other sign of central mischief, the medical man will examine the state of the secretions, ascertain the absence or presence of worms, the condi-

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tion of the mouth and other parts which might give rise to reflex paralysis,[1] and if he find there no clue to the cause of the disease, his next object will be to discover whether the case be one in which the condition is likely to continue, or one in which the loss of power is merely temporary. For this purpose, as well as for subsequent treatment, he must have recourse to different forms of electricity, the use of which should, if possible, commence between the twelfth and thirty-sixth hour of the attack.

To gain information from galvanism it is necessary to use two sorts of battery—the one a single or double cell, with an induction coil and a connection-breaker or hammer; the other a simple galvanic apparatus for producing a constant current of great tension and small quantity. Although for the first-named or induced current any battery with a small coil and means of regulating will do, yet Stöhrer's large double-celled battery is by far the best apparatus I have yet come across. The many means of regulation give great power of minute adjustment; the connection, by standards, of the secondary current enables us to use the least painful stream with the greatest effect; and the attachment of the striking plate of the hammer to a spring enables us to make the widest possible interruptions. For the constant current a battery made originally for me by Messrs. Weiss is the best I have yet found. It consists of fifty elements, three-quarters of an inch wide by two inches and a half long. In a certain number of cases many less cells will answer for treatment, but a smaller battery would, for purposes of diagnosis, fail in so large a proportion of cases as to be almost useless.

The behaviour of muscles to one current and to the other, and the alternation of such behaviour, afford, when properly studied and understood, a mode—indeed, the only mode—of diagnosing the condition and prognosing the future of an infantile paralysis. In the form of this malady (the only paralysis really peculiar to infants) which is not cerebro-spinal or reflex, sensibility of the muscles to the induced current rapidly declines and becomes extinct. This phenomenon commences between the twelfth and thirty-sixth hour. It is usually complete within four days. If, then, the induced current have been used twelve hours after the occurrence of a paralysis not heralded by either severe illness or accident, and the muscles be found tolerably sensitive, we must remain very doubtful as to the nature of the case. If within twelve hours more the sensibility have diminished, we have to do with a case at all events of no temporary paralysis. If in a few more hours faradaism produce no muscular contractions we may feel sure that the disease is one of peripheral origin.[2] If about the time when the power of the induced current decidedly declines—perhaps two or three days after its disappearance—the muscles begin to respond with abnormal sensitiveness to the constant current, but at other times remain flaccid, the case is undoubtedly true infantile paralysis, which will not get well save by careful and more or less protracted treatment. If, however, the case be brought under skilled managament sufficiently early, and treatment carried on with patience and watchfulness, one may in most cases set every muscle free, and this merely by the proper use of galvanism and faradaism. Hence I must be permitted to speak very strongly on the impropriety of postponing treatment under the impression or the hope that the case is but temporary. A muscle or set of muscles which do not recover power in three days will scarcely ever of themselves regain any useful amount of action. If we attack paralyzed muscles while they are still sensitive to galvanism we may in a few weeks restore power; if we wait till not only the induced but the constant current has lost all influence, years will barely suffice to restore any action; to do this other means, as the unusual employment of potent drugs, become necessary, and then the result is problematical.

[1] Certain conditions of the genitals will form the subject of a future lecture.

[2] In an article published by me last year in "St. Thomas Hospital Reports," I have proved very clearly that infantile paralysis is no central disease—neither congestive, inflammatory, nor nutritive.

As to the mode by galvanism I shall say in this place very little, as by relating the details of a case—somewhat rapid in its success, it is true—all essentials may be taught. Certain facts and conditions only need be pointed out—firstly, the necessity of having all the instruments in good order and free from rust; secondly, of never using more power than absolutely necessary, and, especially with children, avoiding pain or alarm as much as possible; thirdly, since every muscle has a point where even a feeble current may cause contractions, while everywhere else a current strong enough to produce severe pain will have no effect on the organ, these points should either be so studied that there never is a blunder about the place to be touched, or else the practitioner must construct a chart, and, while using galvanism, have it in front of him.[1] Lest the term "constant current" mislead, it will be well to explain that the muscular contraction does not depend on the quantity or intensity of the current at any particular moment, but on alternations and amount; hence the twitch only takes place on closing, occasionally also breaking the circle, and not while the stream is flowing uninterruptedly through the organ. "Constant current" is, therefore, a misnomer; the word should have been "direct current," had not such term already been appropriated to another use.

Emma T———, aged four months, was paralyzed during the night of May 10th, 1870. On the 15th she was brought to me —i. e., about one hundred hours after the occurrence. The child was put to bed perfectly well on that night. She had cried a little unusually on being bathed, which the nurse attributed to sleepiness. She also seemed well the next morning, save that the left leg was completely paralyzed, but was in no wise either tender or painful. I found no tenderness anywhere; no heat, thermometric or otherwise; no sign of ill-health or disease. She is rosy, laughs easily, and has evidently suffered nothing. Previous to my seeing her the patient had had an emetic administered, and had been purged. The excretions are in perfect order.

I tried faradaism, gradually increased to the limits of the bearable; neither with the primary nor with the secondary current could the slightest twitch be produced. The battery current with fifty cells produced no movement. In sixteen hours I tried the battery current again; and a third time in twenty-four hours more—i. e. 140 hours after the attack. On the last occasion slight movement in the flexors of the leg, and a more doubtful movement in the extensors, was produced.

May 24th.—Every twenty four hours each muscle has been separately galvanized. The flexores cruris—the deep layer at the back of the leg—act energetically to thirty cells; the extensors both of leg and foot, and especially the adductors femoris, respond more feebly to fifty cells. The sural muscles do not act at all, but let the current go right through them to the deep layer without showing a sign of life. There is neither voluntary power nor faradaic irritability in any muscle. An elastic band is fixed to the shoe, so as, without restraining it, to keep the foot more or less at right angles to the leg. The electric occurrences are these: At an uncertain time, during the first 100 hours, faradaic irritability ceased; at the 120th—130th hour galvanic irritability in certain muscles commenced, and has increased. Other muscles then became galvanically irritable; and now all respond more or less, except the sural muscles. Prognosis guarded, but by no means bad.

June 3d.—The muscles are now all sensitive, except the sural; these, though they respond slightly to the current, are sluggish, and act but little.

July 14th.—The response of all the muscles to galvanism has been becoming more feeble and uncertain. This day Stohrer's battery was used; and I was pleased to find all the muscles respond, and surprised to find that the sural muscles, which had never acted well to the constant current, and had also like the others refused to answer to faradaism, responded now to the coil as well as any.

[1] A number of charts in Ziemssen's work—although they contain, I think, some errors—would answer the practitioner's purpose extremely well.

The prognosis now given was perfectly hopeful; patience and perseverance all that are required.

Dec. 1870.—I took occasion to examine this child. The leg is smaller than the other, and about one-third of an inch shorter; but she can move it in every direction; and in walking or running the limp is barely perceptible. I ought to say that the elastic force was, during three months, used on one side of the leg to prevent a threatening deformity; but this part of the case belongs to another division of our subject.—*Lancet*, April 30th, 1872.

HOSPITAL NOTES AND GLEANINGS.

Case of Disease of the Brain—Left Hemiplegia—Mental Affection.—A patient æt. 56 is under the care of Dr. HUGHLINGS-JACKSON, in the London Hospital. His mind is much impaired, but he has mind enough to frame delusions. A recent fancy is that he wishes to be killed. The most striking feature in his case has been an inability to recognize places and persons. At one time he did not know his own wife; he gave his watch away, and having wandered from home was unable to find his way back. But at the present time he is better, and can name things he sees in pictures, and can read. There seems now to be only a general imperfection of mind, hebetude, and slowness. His wife reports that he has called things by wrong names. Such blunders may arise either from non-recognition of the thing to be named, or from inability to find the name of it.

He has recovered from left hemiplegia—a symptom which, in the vast majority of cases, points to disease of the right side of the brain. In many cases of left hemiplegia there is no striking mental affection. But this patient's palsy was of the rarer kind, in which the leg is more affected than the arm. Trousseau has spoken of the evil omen of cases of hemiplegia in which the leg suffers more than the arm—or, rather, of cases in which the arm recovers, the leg remaining paralyzed. He appears to refer—in part, at least—to mental affections. Dr. Hughlings-Jackson supposes that the lesion in his patient is in the right posterior lobe. As there has been severe earache of the right side, and as there is deafness of that side, the lesion is possibly cerebral softening or abscess from plugging of veins. The hemiplegia came on after the earache, and after the onset of the mental symptoms; it was transitory, lasting about a fortnight.

From anatomical facts Dr. Hughlings-Jackson is led to believe that the "important" part of the right hemisphere is the posterior lobe, whilst the "important" part of the left is the anterior lobe. But it must be remarked that in Trousseau's patient, and in a similar case from Dr. Ramskill's practice, mentioned by Dr. Bazire, the hemiplegia was of the *right* side. However, Dr. Hughlings-Jackson thinks that there is more often mental affection, other than affection of speech, in cases of left than in cases of right hemiplegia, and particularly when the leg suffers more than the arm.

That the anterior and posterior lobes have different functions is certain, as the convolutions of the two cerebral regions have different structure (Lockhart Clarke). Some years ago Dr. Charlton Bastian expressed his opinion that the posterior rather than the anterior lobes are concerned in the highest intellectual operations. The following statement by Rosenthal is strongly in favor of Bastian's opinion: "In the case of new growths in the posterior lobes the psychical disturbances are incomparably more frequent than in that of tumours of the anterior or middle lobes."

Dr. Hughlings-Jackson grants that the clinical evidence as to the greater importance of the *right* posterior lobe in mental operations is slender; but the anatomical facts (Gratiolet, Broca, and Barkow) are strong. (These facts he has several times referred to when speaking of the question of the supposed greater importance of the *right* posterior lobes in this journal, August 22, 1868, pp. 208–9; September 26, 1868, p. 358.) And the hypothesis may have at least this value: that it will lead to a careful study of the *kind* of mental affection—when there is any—which attends hemiplegia, especially when the leg is the limb more affected. We have many facts

as to the kind of mental affection (phasia) which so often attends lesions in the region of the *left* corpus striatum, and it is legitimate to inquire if there be not symptoms as *special* from lesions in the neighbourhood of the *right* optic thalamus. The former, when speech is *lost*, consists in an inability to reproduce words and to reproduce them in propositional order; but in cases of loss of speech—in chronic cases at least—there is no difficulty in the reproduction of images of objects. The patient can recognize handwriting, although he cannot read; he can copy print into writing, but cannot express himself in writing; he may be able to play at dominoes or cards. In these operations speech is not concerned; the operation of *another* series of sensori-motor processes is required. Dr. Hughlings-Jackson believes his patient has, or has had, defect in this other series—in the sensori-motor processes concerned in the *recognition* of objects (not in *seeing* objects), and in putting images of things in "propositional order," so to speak. Such a defect, when extreme, would pass as one of imbecility, and in a minor degree as one of "loss of memory." Obviously the investigation of such cases will be very difficult indeed.

Just as we compare and contrast the effects of plugging of the left and right middle cerebral arteries, so we should compare and contrast the effects of plugging of the right and left posterior cerebral arteries. Dr. Hughlings-Jackson, however, has seen but one case of plugging of the posterior cerebral artery; and as both the right and left, and also the right middle cerebral were plugged, the case, although there was mental affection, is not evidence either for or against the hypothesis he has put forward.

In the above remarks spectral illusions are not spoken of; but these, if the above hypothesis be correct, will depend on disease of the posterior lobe. The *disorderly* revival of images bears the same relation to *inability* to revive images as chorea does to hemiplegia—in the former there will be instability of nerve-tissue, in the latter destruction of nerve-tissue.—*Med. Times and Gazette*, May 4, 1872.

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Cases of Sick Headache treated successfully by Indian Hemp.—There are at Middlesex Hospital, under the care of Dr. John Murray, two female patients, the one æt. 41, the other 50, both married, who have been for many years subject to sick headache. They have been greatly benefited by the administration of ten-minim doses of tincture of Indian hemp three times daily, between the attacks. The hereditary character of the affection is well exemplified in both. In one case there is a history of the mother and four sisters suffering from similar attacks; while the other patient states that her aunt was subject to sick headaches and died insane, that a sister suffered from frequent severe headaches without sickness, and that a brother was a deaf mute and had sick headaches.—*Lancet*, April 30, 1872.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

American Medical Association. — The twenty-third annual meeting of this Association was held in Philadelphia, May 7, 8, 9, and 10. Over 700 delegates were present.

The Convention was called to order by the President, Dr. D. W. Yandell, of Kentucky, and the proceedings were opened by prayer by the Right Reverend William Bacon Stevens, M.D., Bishop of Eastern Pennsylvania.

An address of welcome on behalf of the medical profession of Philadelphia was delivered by Dr. R. E. Rogers, Chairman of the Committee of Reception, and Dr. Edward Hartshorne, Chairman of the Committee of Arrangements, announced the programme.

The annual address of the President was then delivered.

Dr. H. F. Askew, of Delaware, moved the reference to the Committee on Ethics, without debate, of all questions of a personal character, and all questions relating to credentials. On the call of the previous question it was passed by an overwhelming vote. The Chair appointed the following Committee on Ethics: Drs. H. F. Askew, of Delaware, N. S. Davis, of Illinois, Calvin Seavy, of Maine, J. K. Bartlett, of Wisconsin, and S. D. Gross, of Pennsylvania.

In the evening a promenade concert was given in Horticultural Hall, and a reception in the Foyer, by the Biological and Microscopical Section of the Academy of Natural Sciences. There were exhibited beneath more than one hundred choice microcopes, arranged on two long tables appropriately lighted, numerous specimens of pathology, anatomy, microscopic photography, etc. The spectra of numerous substances were shown by the aid of five spectroscopes.

May 8. The Nominating Committee of one from each State was appointed by the State delegations.

Dr. Bronson, of Massachusetts, offered the following amendment to the By-laws:

Resolved, That the Committee on Ethics, to consist of seven members, be nominated by the Nominating Committee. Lost.

Dr. N. S. Davis, of Illinois, offered the following:—

Whereas it has been represented that the Massachusetts Medical Society considers that its delegates to the annual meeting of the American Medical Association in Washington, May, 1870, were unjustly excluded by the Committee of Arrangements; and

Whereas the action of the Committee on Ethics, at the same meeting, in refusing the right of said Committee of Arrangements to exclude the Massachusetts delegation, is not yet fully understood by that society; therefore

Resolved, That the Association acknowledge the great and effective efforts of the Massachusetts Medical Society to elevate the profession, and to suppress quackery of all sorts, and especially assure that society of encouragement and support in its present exertions to rid itself of all pretenders.

Referred to the Committee on Ethics.

Dr. F. G. Smith, of Pennsylvania, presented the Report of the Committee of Publication. It set forth that 750 copies of the Transactions of the Society had been published, at a cost of $1549.39.

Dr. Caspar Wister, of Pennsylvania, treasurer, reported that the Association last year exercised a praiseworthy discrimination in the selection of the material furnished for publication, and consequently the volume of Transactions was smaller, more compact, cheaper and more desirable to the profession than heretofore. The edition was published at a price which leaves a balance on hand for the use of the Association when it may hereafter become forgetful of its prudence, and refer a great mass of manuscript for publication. The treasurer counselled care in the adoption of prize essays, for out of this has arisen a considerable expense. The treasury is depleted annually to the extent of $200, which it can ill afford. The account current shows a balance in hand of $1005, being about $300 more than was in hand last year. The Treasurer asked the Association to bear in mind that there are no discretionary powers vested in the Committee of Publication. They must publish everything which is referred to them by the sections. Referred to the Publication Committee.

Dr. J. S. Weatherly, of Alabama, presented the Report of the Committee on Medical Education. Referred to the Committee of Publication.

Dr. F. A. Ashford, of the District of Columbia, Librarian, presented his report. Referred to the Committee of Publication.

The Committee on Prize Essay presented their report, awarding the annual prize to Dr. Samuel R. Percy, of New York, for an essay on the subject of "What physiological value has phosphorus as an organismal element?"

Dr. Theophilus Parvin, of Indiana, presented the report of the Committee on Medical Literature, and advocated the publication, under the auspices of the Association, of a medical journal, instead of the annual volume of Transactions. Referred to the Committee of Publication.

Dr. J. D. Jackson, of Kentucky, presented the report of the Committee on American Medical Necrology. Referred to the Committee of Publication.

Dr. William R. Findley, of Pennsylvania, presented a resolution which declared that as the Association, at its meeting in 1869, unanimously adopted a resolution classing all who practised medicine on the "contract system" with "irregular practitioners," and as this action has excited considerable controversy in many of the

county societies, the members of which have misunderstood the meaning of that resolution, it is therefore important that the Committee on Ethics decide whether such physicians are really "irregular." Referred to the Committee on Ethics.

Dr. Sutton, of Indiana, presented a special report upon comparative pathology, and advocated the formation of a great medical library, open to all.

Dr. Woodward, of the U. S. Army, stated that the national medical library, which Dr. Sutton considers so desirable, is already in existence; that the library of the Surgeon General's Office in Washington has been furnished with funds during the last four or five years by Congress, and has been accumulating books until it now contains some eighteen thousand volumes, and that there is every probability that a large appropriation will be granted during the present session for its continuance.

Dr. Stetler, of Pennsylvania, offered the following:—

Resolved, That no report or paper which is referred to the various sections shall be referred by the latter to the Committee of Publication without first having been examined and approved by two-thirds of the members present at said section.

Indefinitely postponed.

In the evening, in addition to the hospitalities extended by citizens, the delegates were entertained with a lecture by Dr. H. D. Noyes, of New York, on "The relation of disease of the inner structure of the eye to other affections of the body," illustrated by ophthalmoscopic pictures projected upon a screen by means of the magic lantern, in the lecture-room of the medical department of the University of Pennsylvania.

At eight o'clock Professor Robert E. Rogers, of the University, delivered a brief lecture on the two subjects of the Spectroscope and Electricity. He first explained the action of the spectroscope in analyzing the light of the sun and other heavenly bodies, and also that produced by the combustion of minerals and gases, and in illustration, he projected upon a screen the spectra of several of the substances alluded to.

May 9. The following preamble and resolutions adopted by the College of Physicians of Philadelphia were offered:—

Whereas cases of accidental poisoning and of the internal administration of medicines intended only for external use are so frequent; and

Whereas every possible safeguard should be employed to prevent such accidents; therefore

Resolved, That it is recommended to all druggists to place all external remedies in bottles not only colored, so as to appeal to the eye, but also rough on one side, so that by the sense of touch no mistakes shall be possible even in the dark; and that all bottles containing poisons should not only be labelled "poison," but also with another label indicating the most efficient and convenient antidote. Adopted.

Dr. Alexander W. Stein, of New York city, presented the following:—

Whereas it has long been recognized that diseases of a dangerous and fatal nature are transmissible from animals to man, and that certain zymotic affections, which are common to both man and animals, do very frequently manifest themselves, first in the latter and subsequently in man, thus warning us that to be indifferent to the condition of the inferior animals is to introduce and create centres of diseases among ourselves; therefore

Resolved, That a committee be appointed to ascertain what measures can be instituted to prevent the extension of such diseases to man, and what sanitary measures can be effected to arrest the progress of such diseases in animals, the committee to report next year. Adopted. The Chair appointed Drs. Stein, of New York, Sutton, of Indiana, and S. D. Gross, of Pennsylvania.

Dr. Frederick Horner, of Virginia, proposed the following:—

Whereas the abuse of ardent spirits in our country has proved injurious to the health of the community,

Resolved, That the members of this Association are recommended to discourage the use of alcoholic stimuli in their practice. Adopted.

Dr. Walker, of New York, presented a resolution providing that so much of the

report of the Committee on Literature as relates to the establishment of a National Medical Journal, be referred to a special committee. Agreed to.

The president appointed the following committee: Drs. Pollock, of Pa.; Westmoreland, of Ga.; Talley, of S. C.; Walker, of N. Y.; Jackson, of Ky.; Weatherly, of Ala.; and McGuire, of Va.

Dr. Francis G. Smith, of Pennsylvania, chairman of the Committee on Nomenclature of Diseases, reported that, in accordance with instructions given to them by the Association in 1870, they had prepared a nomenclature to be adopted and observed by the practitioners of the United States. The system presented by the committee is based upon that of the Royal College of Physicians of London, with such additions and modifications as in the judgment of the committee were needed. In selecting Latin equivalents the committee had frequently departed from the English nomenclature, and so far as possible the English rather than the Latin terms have been employed.

The report had appended to it the following:—

Resolved, That the report of the Committee on Nomenclature of Diseases be referred to a special committee of five members, to be appointed by the president, who shall examine it and report upon its final disposition at the present meeting of the Association.

Resolved, That on the favorable report of said committee it shall be referred back to the Committee on Nomenclature for the preparation of an index.

Dr. Woodward, of Washington, on behalf of the minority, reported that, while they have the highest respect for the ability and learning of those members of the committee whose residence in Philadelphia has enabled them to attend its meetings and aid in the production of the report just read, they nevertheless feel it a duty to express their earnest convictions that the adoption of a nomenclature and a classification by this Association is a matter of too great importance to be acted upon hastily, and before any of the members of the Association, except a part of the committee, have had any opportunity to examine for themselves the nomenclature and classification which it is now proposed that we shall adopt. The minority of the committee had no opportunity to examine the proof sheets of this work until the commencement of the present meeting.

The resolution appended to the minority report was as follows:—

Resolved, That the nomenclature and classification just submitted by the committee be published in the Transactions; that one thousand extra copies be printed in cheap pamphlet form and distributed to the profession, and that the question of the adoption of the nomenclature and classification by this body be postponed until the next annual meeting.

The resolution appended to the minority report was adopted.

Dr. William O. Baldwin, of Alabama, presented the following report of the Committee on Nominations:—

President—Dr. Thomas M. Logan, of California.

Vice-Presidents—Drs. B. H. Catlin, of Connecticut; McPheeters, of Missouri; Pollock, of Penna.; and Briggs, of Tenn.

Treasurer—Dr. Caspar Wister, of Penna.

Librarian—Dr. William Lee, of D. C.

Permanent Secretary—Dr. William B. Atkinson, of Pennsylvania.

Assistant Secretary—Dr. Montrose A. Pallen, of Missouri.

Committee of Arrangements—Drs. J. B. Johnston, J. T. Hodgen, J. P. Moore, Robinson, Kennard, Leete, Brokaw, and J. M. Scott, all of Missouri.

Committee on Library—Dr. J. M. Toner, of District of Columbia.

The place of next meeting—St. Louis, Missouri. Adopted.

Dr. Keller, of Kentucky, presented the following:—

Resolved, That so much of the report of the Committee on Education as refers to the establishment of a medical congress, consisting of an equal number of representatives from each State, is of immediate importance, and, in order to further the views thus expressed, that a committee be appointed at once to take the preliminary steps necessary to organization with instructions to report before the adjournment of this convention. Lost.

Dr. Montrose A. Pallen, of Missouri,

presented a proposition for the establishment of a National Academy of Medicine, for the purpose of elevating the standard of medical attainments and the moral worth of its members. Lost.

Dr. Logan, of California, chairman of the Committee on Public Hygiene, presented a report, in which the committee ask to be constituted a special section on State Medicine and Public Hygiene, to which all subjects cognate thereto may be referred; also that they be empowered to take such action, in connection with the authorities at Washington, as in their judgment may be deemed expedient in carrying out the objects of the resolutions.

Dr. J. C. Tucker, of California, offered a substitute recommending to Congress to establish a National Sanitary Bureau, in charge of six competent medical men, to be appointed by the Secretary of the Treasury of the United States, from physicians nominated by this Association. The substitute was, on motion, laid upon the table.

The resolutions contained in the report of the committee were adopted, after striking out the portion empowering the committee to confer with the Government at Washington.

Dr. Keller, of Kentucky, moved that when papers are referred to the Publication Committee, with instructions to that effect, they are to be published, but when without definite instructions the Committee will exercise its discretion.

The resolution was discussed and several amendments were offered. A long debate ensued upon the powers and privileges of the Publication Committee with regard to the publication of papers presented to them. On motion of Dr. Davis, of Illinois, the whole subject was indefinitely postponed.

Dr. Askew, of Delaware, from the Committee on Ethics, presented a report, which was read by Dr. Davis, of Illinois, secretary, and each section of which was acted upon by the Association immediately on being read.

In relation to the preamble and resolutions offered by Dr. Davis, of Illinois, touching the Massachusetts Medical Society, the committee recommended them for unanimous adoption by the Association. Adopted.

The committee report in regard to the official communication of the Corresponding Secretary of the Medical Society of the District of Columbia, certifying that Drs. Bowen, Bond, Williams, Crouse, Phillips and others have forfeited their membership in that society by reason of not having paid their dues for three years, and after repeated notice of the fact and its consequences—the committee recommend that their names be stricken from the roll of membership; and also the same action in regard to Dr. D. W. Bliss, who is under sentence of expulsion from that society. Unanimously adopted.

In regard to the alumni associations of medical colleges, the committee reported that it did not consider them such medical societies as were intended, by the constitution, to be eligible to membership, and hence they recommend that no delegates be received from any of the alumni associations of any of the medical colleges from any part of the country. Unanimously adopted.

In regard to the Pathological Society of Berks County, Pa., the registration of whose delegates had been postponed on account of the protest alleging the want of good standing on the part of that society, the Committee postponed action from the want of proper evidence.

In regard to the Academy of Medicine of Washington, D. C.; the Freedmen's Hospital, of the District of Columbia, and the Howard University of Washington, D. C., the registration of whose delegates had been postponed by the Committee of Arrangements on account of want of good standing on the part of those institutions, as indicated by the action of this Association in 1870 and 1871, the Committee report the facts as follows: First, that this Association, at its meeting in San Francisco in 1871, by the emphatic vote of 83 to 26, refused to so amend the constitution as to admit delegates from colleges in which women are taught and graduated in medicine, and from hospitals in which women, graduates in medicine, attend. Second, that this Association, in 1870, declared, by an almost equally emphatic

vote, that a medical society constituted in part by members who were not licensed to practise in accordance with the civil law governing such cases in certain States, is not entitled to representation in this Association. Third, that sections 3, 4, and 5 of the act of Congress, passed July, 1838, incorporating the Medical Society of the District of Columbia, and which has been the law regulating the practice of medicine in that District up to the present time, requires all persons coming into the District to practise medicine to apply for, and within six months obtain, a license to practise from the Board of Examiners, and to effect that purpose makes it a misdemeanor, accompanied by a fine of $50, to practise without such license. Fourth, that it has been proven by the testimony of several witnesses that the Medical Society of the Academy of Medicine of Washiugton, now contains in full fellowship at least four or five members who have never applied for and obtained licenses to practise, and yet are actually practising medicine, and three of whom are on the list of delegates sent by that society to this Association; also, that one of them is a member of the medical staff of the Freedmen's Hospital, and also that several of the faculty of the Howard University are members of the same Academy of Medicine, and one of the teachers is a woman.

In view of these facts, the committee cannot regard either of the three institutions named as in good standing, whether tested by civil law, by the former decisions of this Association, or by its code of ethics, and hence the committee recommend that the delegates from those several institutions be not admitted into this body.

After an animated discussion and the call of the previous question, this portion of the report was adopted by an overwhelming majority.

The Committee on Ethics offered the following:—

Resolved, That the members of the profession hired by the month or year for definite wages, by families, railroads, manufacturing corporations, or any money-making institution whatever, for ordinary surgical or medical practice, always excepting eleemosynary and charitable institutions and hospitals, are to be classed as irregular practitioners, and, therefore, disqualified for membership in this Association, or in State or county societies.

Dr. Weatherly, of Alabama, moved to refer this question back to the State societies. Agreed to.

In the evening a lecture, illustrated by numerous interesting experiments, was delivered by Dr. J. Solis Cohen, at the Jefferson Medical College.

May 10. A resolution was offered placing the United States Marine Hospital Service in the same relative position in this Association as the Medical Department of the army and navy, and making the necessary alterations in the constitution. Laid over for one year.

Obituary resolutions were passed upon the death of Dr. Zina Pitcher, of Michigan; and Drs. Samuel Jackson, Wm. W. Gerhard, and Samuel Henry Dickson, of Pennsylvania.

Dr. S. D. Gross, of Pennsylvania, proposed as an amendment to the By-laws, under the head of Standing Committees, that instead of a report on medical education, on medical literature, and climatology and epidemic diseases, there shall annually be delivered before the Association, at its general meeting, an address on medicine, an address on surgery, and an address on midwifery, or the diseases of children—the lecturers to be appointed by the Nominating Committee.

The amendment was laid over to the next meeting.

Dr. E. Lloyd Howard, of Md., presented a resolution for the appointment of a committee of three, to report, at the next meeting of the Association, a plan for a better arrangement of the sections, and for the more rigid examination of the papers offered for publication. Agreed to, and the president appointed on the committee Drs. Howard, of Maryland, Bronson, of Massachusetts, and R. E. Rogers, of Pennsylvania.

Dr. Alexander W. Stein, of New York, offered the following:—

Resolved, That the committee appointed by this Association in Washington, D. C., in 1870, to report on what means are ex-

pedient to prevent the renewal of prescriptions by druggists without the consent of the physician ordering said prescriptions, be continued one year. Agreed to.

Dr. Skillman, of Kentucky, presented a resolution acknowledging the services of Dr. William B. Atkinson as Permanent Secretary of the Association, and appropriating to him an annual salary of $1000.

On motion of Dr. Davis, of Illinois, it was resolved that, in view of the present prosperous condition of the treasury, the Permanent Secretary shall receive from the Association a present of $500 as a token of their appreciation of his services.

On motion of Dr. Parsons, of New York, the case of Dr. Paluel De Marmon, of New York, was referred to the Committee on Medical Ethics, with instructions to report at the next annual meeting.

On motion of Dr. Baldwin, of Alabama, a special committee was appointed, with Dr. Sullivan as chairman, to consider the relations between physicians and druggists, and report at the next meeting.

Dr. Reese, of New York, offered the following:—

Resolved, That while we admit the right of woman to acquire medical education and to practise medicine and surgery in all their departments, we deem the public association of the sexes in our medical schools and at the clinics of our hospitals as impracticable, unnecessary, and derogatory to the instincts of true modesty in either sex.

The consideration of the resolution was, without discussion, indefinitely postponed.

The President announced that as the business before the Association had been disposed of, he declared the Association adjourned, to meet in St. Louis on the first Tuesday in May, 1873.

On the adjournment of the convention, the Association visited Fairmount Park, by invitation of the medical profession of Philadelphia. After viewing the beauties of the Park, they partook of a collation at the Pavilion.

On the days of the Sessions of the Association there were exhibited in the Hall of the College of Physicians a large, varied, and novel collection of chemical and electrical apparatus, of pathological and anatomical specimens and diagrams, of chemical and pharmaceutical preparations, of medical, surgical, and obstetrical instruments, of instruments of precision, and of the recent medical publications. In the book department, which was particularly interesting, there were displayed beneath four large show-cases a number of curious, rare, and valuable prints, many of them illustrating the early history of American medical literature. Most of the latter were drawn from the valuable collections of Dr. Gilbert and Prof. Carson of Philadelphia. Dr. Gilbert also exhibited a number of portraits of men distinguished in early American medicine; among these was an original by Benjamin West of Dr. Benjamin Rush at the age of twenty-three.

Thus ended the largest and one of the pleasantest meetings of the American Medical Association that has ever been held. Assembled together under circumstances which led the less sanguine to believe that it was for the last time, the Association, on the first day of its session, by an overwhelming vote recorded its determination to prevent the agitation of those subjects which had disturbed the peace of recent meetings. And when those subjects in due course came under consideration, they were treated with the deliberation that their importance demanded, and disposed of by such an enormous majority as to justify the hope that they will not again be intruded upon the Association.

—

Calabar Bean in Cerebro-spinal Meningitis.—Dr. N. S. Davis states (*Medical Examiner*, April 1, 1872) that he has used the Calabar Bean either alone or in combination with ergot, with more apparent effect in controlling cerebro-spinal meningitis than any other remedy he has tried. The following was his prescription for a case in a child 11 years of age. "℞— Tinct. Calabar bean ℥j; Fl. extr. ergot. ℥jss." M. A teaspoonful to be given every two hours.

—

Cimicifuga Racemosa as a Preventive of Smallpox.—Dr. G. D. Norris, at a recent meeting of the Alabama State Medical Association, "stated that during the prev-

alence of smallpox in Huntsville, certain families, at the instance of some one unknown, had resorted to the free use of the *tea of the cimicifuga racemosa*, or black snakeroot of the United States Pharmacopœia (*cohosh*), *as a preventive of smallpox*. In the families using the cimicifuga, there occurred no case of the smallpox, though some were exposed to the disease. In the same families, Dr. Norris vaccinated the members, but without effect so long as they continued the use of the cohosh; after ceasing to use the tea as a prophylactic, he again vaccinated them, when the specific effects of the vaccine virus were produced. He submitted the results in these cases as new, and not without interest to the profession."—*Atlanta Med. and Surg. Journal*, April, 1872.

—

Medicinal Powers of Eucalyptus.—Dr. David Wooster calls attention (*Pacific Med. and Surg. Journ.*, May, 1872) to the effects of the fluid extract of the Eucalyptus. He states that he has "used some gallons of it during a period of eight months in the U. S. Marine Hospital, and was surprised at its uniform and reliable effects in affections for which it is suitable. It is a diuretic of rare virtue, and may be administered when most of the diuretics now in common use are inadmissible. It is an aromatic tonic, and has notable restorative effects in low states of the system, as in typhoid fever, typhoid diarrhœa, and dysentery.

In vesical catarrh it alone cures. In spasmodic stricture it relieves with great promptuess. In all affections of the mucous membranes its beneficial action is remarkable. We have treated many cases of acute gonorrhœa with no other remedy. Per contra, in syphilis it is useless except as an alterative.

It has no antiperiodic action. It relieves headache apparently as the saline diuretics do, by its diuretic action.

As an external application in chronic ulcers, it has great value.

It does not impair but rather improves the appetite.

—

Medical College of the State of South Carolina.—The following changes have been made in the faculty of this school. Dr. E. Geddings has resigned the chair of Clinical Medicine, and is appointed Emeritus Professor of the Institutes and Practice of Medicine. Dr. F. Peyre Porcher has been appointed to the chair made vacant by the resignation of Dr. Geddings. Dr. F. M. Robertson has been appointed Professor of Gynæcology and Clinical Obstetrics. Dr. J. Ford Prioleau, fills the chair of Principles and Practice of Obstetrics.

—

Mortality from Smallpox in Philadelphia.—

Week ending April		27th,	deaths	. .	53
"	" May	4th,	"	. .	35
"	" "	11th,	"	. .	50
"	" "	18th,	"	. .	29
"	" "	25th,	"	. .	35

—

Obituary Record.—Died in this city, April 28th, Wm. W. Gerhard, M.D., aged 63. Dr. G. was among the first to teach here the physical signs of the diseases of the chest, and pointed out, in conjunction with the late Dr. Pennock, the differential diagnosis between typhus and typhoid fever. (*Amer. Journ. of Med. Sci.*, Feb. 1837, p. 289.) In 1835, he published a short treatise on the Diagnosis of Thoracic Diseases, and in 1846, a work on "The Diagnosis, Pathology, and Treatment of the Diseases of the Chest," which reached a fourth edition in 1860. For a quarter of a century he was one of the attending physicians to the Pennsylvania Hospital, resigning about four years since.

The Medical Board of the Hospital have adopted the following resolutions expressive of their feelings on the loss the profession has sustained:—

"We have learned with regret of the death of Dr. W. W. Gerhard.

"During the twenty-five years that he was attached to the Hospital Staff, most if not all of us have occupied the positions of both his pupils and colleagues, and in that period have formed strong ties of friendship, arising from his true goodness of heart and conscientious sense of duty. In this intimate intercourse, also, our admiration of his professional talents constantly increased, he fully sustaining the great reputation he acquired both in this country and abroad. Dying, he has left

behind him a name among physicians which few can hope to attain.

"*Resolved*, That we sincerely sympathize with the family in their affliction.

"*Resolved*, That a copy of these resolutions be sent to the family of the deceased. WILLIAM HUNT, *Secretary*."

FOREIGN INTELLIGENCE.

Lostorfer's "Syphilis-corpuscles."— Dr. H. KÖBNER, of Breslau, has recently published an account of his researches on this subject. Having drawn specimens of blood from syphilitic patients, and protected them from air by receiving them into freshly blown glass bulbs with sealed capillary ends, Dr. Köbner found that, after two or three days in a temperature of 52 to 68 degrees Fahr., a few of the red corpuscles presented an indented outline; and, in the interspaces between the red corpuscles, there were colourless homogeneous vesicles, refracting light only a little more than serum, and having an indistinct contour. They differed remarkably in figure, size, and arrangement, in different parts of the same preparation; some were round, others oval, others pear-shaped; some were attached to the red corpuscles, others to the white, and others lay free in the plasma. Some of the vesicles had a minute gray mass attached; others, one or two vesicles, similar in character, but nearly always smaller, producing the appearance described by Lostorfer as gemmation. In some parts, the vesicles were collected in chains of from three to six, or in masses of as many as fifteen. The diameter of the vesicles varied from .0032 to .0015 millimètre (about $\frac{1}{7812}$th to $\frac{1}{16660}$th of an inch); a few only were nearly as large as the red corpuscles. Some of these larger vesicles had a small space in the interior. Similar vesicles were also observed in the interior of the white corpuscles. On the fourth, fifth, and sixth days, the vesicles had increased in number, and some of them had become aggregated into masses. In these masses, the vesicles were nearly of the same size—about half as large as a red corpuscle; elsewhere, they varied as before in size and form. Here and there small vesicles were observed within, or at the edge of, masses of detritus. From observations extending over three weeks, Dr. Köbner became convinced that these vesicles were neither oil-globules nor cryptogamic spores. This was shown not only by their general characters and their reaction to various chemical reagents, but also by the fact that they decreased and at last disappeared, while the *bacteria* and *mycelia* increased. Although, then, these vesicles were of no pathogenetic importance, still their exclusive occurrence (as asserted by Lostorfer) in syphilitic blood might have a diagnostic value. But, on examination, Dr. Köbner found similar appearances in the blood of patients suffering from smallpox, eczema, lupus, and acne, as well as in the blood of syphilitic patients who had been treated with mercury and iodine, and in healthy blood. The number of vesicles observed in specimens of blood from the same patient was much modified by certain accidental circumstances, especially by the rapidity with which the blood was covered in. The corpuscles were fewest, or even none, in blood which was not covered in for several minutes. Dr. Köbner then varied the method of observation in several ways. When the specimen was immediately covered in with varnish, and placed in a water-bath of 25.36 degrees Cent. (77.97 degrees Fahr.), a number of the vesicles appeared in the course of an hour; while in similarly prepared specimens from the same subject, lying in the same room, at a temperature of 50.63 degrees Fahr., scarcely one could be found. On examining the specimens from one quarter of an hour to another, he was able to see, at the end of two hours, that a number of new vesicles had been formed in the islets of protoplasm; and that, in some instances, two became joined in a round, cylindrical, or oval body. Being at first inclined to suppose that these appearances might be due to the living plasma, and bearing in mind the experiments of Binz on the action of quinia on the amœboid colourless corpuscles, Dr. Köbner compared the blood

taken from the puncture made in injecting a quinia solution in a case of neuralgia with some blood taken from a finger of the same patient, and on the next day found that the latter contained numerous vesicles, and the former none. Another similar observation, however, showed that the difference depended on some accidental circumstance; for both specimens contained the vesicles. Various observations with specimens prepared in the moist chamber, and by cementing, with or without the application of warmth, showed similar differences in the blood of healthy persons, and those suffering from smallpox and other diseases. For instance, in specimens of healthy blood cemented in immediately after being drawn, vesicles were met with in an hour, and were greatly increased in quantity when warmth was applied; while in other specimens, placed at the same time in the moist chamber, the vesicles did not appear till two, four, or five days. Dr. Köbner observed the development of the vesicles in the plasma of the blood, by using a fenestrated heated chamber, such as has been devised by Professor Cohn for observing the movements in vegetable protoplasm. As the temperature was raised, their number was perceptibly increased; and they gradually ran together here and there, until at a heat of 102 degrees Fahr. they diminished, and at 115 degrees Fahr. shrank up. As to their nature, he believes them to be vacuoles, such as were first described by Dujardin in the sarcode of infusoria, and lately studied by Cohn and Braun in the cells of plants. At a meeting of the Vienna Medical Society on April 26, Dr. Stricker remarked that no one indeed would believe that Lostorfer's corpuscles were organisms, or that they formed the essence of the syphilitic virus; and hence, after all that had been said on the subject, there was just as much obscurity as before as to their nature.—*Brit. Med. Journ.*, May 11, 1872.

Dr. F. J. Bumstead, in a letter to the *Medical Record* (May 15th), states that Prof. Stricker, than whom there can be no higher authority, and who has been carefully examining Lostorfer's so-called "syphilis-corpuscles," has come to the conclusion "that the presence of these bodies is due to the impairment of nutrition and the cachectic condition of the individual, and not to the existence of syphilis or any other one disease exclusively."

Prof. S. has examined the blood of "six persons free from syphilitic taint, but whose nutrition and vital powers were impaired by different diseases, and blood from all of them exhibited the peculiar "newly discovered" corpuscles of Dr. Lostorfer.

Further, Dr. B. states that Prof. S. has found nothing in the blood answering Prof. Salisbury's description of "crypta syphilitica."

Thus one more supposed wonderful discovery is shown to be a fiction.

—

Deaths from Chloroform.—In the No. of the *British Medical Journal* for May 4, 1872, Dr. Glascott reports a case of this which occurred at the Royal Eye Hospital, Manchester. R. B., aged 48, had chloroform administered to him prior to the operation of extraction of both cataractous lenses. After inhaling one drachm of chloroform poured upon a towel a small quantity was again poured upon it. At the end of about five minutes more the patient began to struggle and breathe irregularly, and his heart's action suddenly ceased (during the whole of the time his conjunctiva was sensitive to the touch). At the autopsy the heart was found considerably hypertrophied and fatty.

The same journal also records another case which occurred May 1, at St. Bartholomew's Hospital. Chloroform was administered to a young man having a phagædenic sore. After a very few minutes, before the patient was fully under the influence of the vapour, the pulse ceased, and all efforts, including galvanism and artificial respiration, persisted in for an hour, proved unavailing to restore life.

—

Heat as a Poison.—It appears from some curious experiments of M. Claude Bernard that heat, when it attains too high a degree, acts on animals like a poison, and destroys feeling and motion. The

precise action of heat on the blood, according to M. C. B., is as follows: the blood of an animal killed by heat becomes black, the oxygen it contains is rapidly transformed into carbonic acid, and finally disappears. This is not a true toxical action, but rather an excitement of the vital and normal properties of the red particles. The black blood of the rabbit killed by heat is still living; it absorbs oxygen by contact with the air, and again becomes ruddy, if the experiment is tried in time. Between 167° and 190° F., however, the blood coagulates, loses its vital properties, and cannot again become red. Heat above a certain degree kills the muscles without killing the blood. The chemical character of this poisoning of the muscles by heat is the most obscure part of the subject. It now remains for chemists to analyze the phenomena which accompany the muscular rigidity and cessation of motion produced by heat, and thus to solve the problem of the precise action of this poison, as they have done in the case of certain others.

—

Myrrh in Dyspepsia.—Dr. Delioux de Savignac, (*Bull. de Therap.* Dec. 15, 1871) writing on the therapeutic properties of myrrh, observes: "The stomach is the portion of the digestive apparatus which has appeared to me to be most happily influenced by myrrh. My experience fully confirms the reality of the stomachic properties which have been attributed to it by the older writers. I have seen painful forms of dyspepsia rapidly relieved, and even cured, by the use of this gum-resin; sometimes I have given it in conjunction with other remedies, such as bismuth, magnesia, bicarbonate of soda, etc., drugs which had hitherto proved ineffectual, and sometimes I have employed it alone, so as to leave no doubt as to the efficacy of its action."—*Birmingham Med. Rev.*, April, 1872.

—

Bromide of Potassium.—It has been said that the prolonged use of bromide of potassium was injurious to the economy in many ways—notably that it caused loss of memory, diminished the appetite, reduced the weight of the body, and even predisposed to phthisis. With a view of satisfying themselves on these points, the following observations were made by the medical officers of the Sussex County Lunatic Asylum, Haywards Heath. Ten patients, four females and six males, were ordered the bromide, in doses varying from twenty to forty grains, three times a day. Their weights were taken weekly, and the effects carefully noted. It would appear from these observations that, when the bromide is given in doses not exceeding one drachm daily, it almost invariably increases the weight of the body; and that even where this dose is doubled the weight need not necessarily diminish, but rather that the chances are in favour of its increasing. The appetite was never impaired, and the functions of the secretory and excretory systems were not perceptibly affected in any instance. As regards the alleged failure of memory, no opinion could of course be formed from observations derived from insane patients; but the medical officers from whom we are quoting state that they have not, in their experience of the remedy, had any evidence in support of such a view.—*Lancet*, April 20th, 1872.

—

Brominated Camphor.—Prof. Deueffe, of Ghent, says (*Presse Med. Belge*) he has for more than two years used a combination of camphor and bromine, to which he calls attention. It is known that bromine and camphor unite at ordinary temperatures, but the product is decomposed by exposure. This compound, Prof. Swartz, of Ghent, has shown, when heated in a closed vessel, is resolved into hydrobromic acid and a crystalline monobromized camphor, i. e., camphor with one atom of hydrogen replaced by bromine. Its fusing point is 76° C, and its boiling point 274° C.

Professor Deueffe has prescribed it in the form of pills, seventy grains in thirty pills, of which he gives one every four hours till twenty have been taken, the dose afterwards increased. He finds it an excellent sedative to the nervous system, and has used it with much success in delirium tremens.—*Birmingham Med. Rev*, April, 1872.

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Its fluency and beauty of language make it as delightful to read as a standard novel.—*Edinburgh Medical Journal,* April, 1872.

If the labor of revision had been undertaken by some inferior workman, there would have been some reason to fear the result of unskilful attempts to patch an old garment with new cloth. Happily, however, the gifted author survives, and, while in the full possession of his high faculties, he has, with great labor, subjected his lectures to a more thorough revision than was possible during the earlier and busier portion of his life. The result is a work by one master-mind, uniform and perfect in style, from the opening sentences of the introductory lecture to the graceful and generous epilogue at the end—a work evincing in a degree rarely equalled calm judicial wisdom, a truly reverent spirit, and an ardent love of truth.—*British and Foreign Medico-Chirurgical Review,* April, 1872.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on a Case of Renal Disease ending in Apoplexy.—By W. H. BROADBENT, M.D., Physician to St. Mary's Hospital.

Gentlemen: The anatomical pieces before you tell a tale to the educated eye far more eloquent and impressive than any I can shape into words. There are the kidneys; there is the heart; there is the brain. The kidneys diminished in size—one especially so—rough and granular on the surface, with here and there a small cyst, and damaged in their intimate structure. The heart enormously enlarged, weighing 19 oz. instead of 9 oz. or 10 oz., the walls of the left ventricle greatly thickened; and this change not accounted for by any alteration of the valves, which are quite healthy and competent. The brain with a large ragged cavity in the right hemisphere, from which a great blood-clot has been extracted. To complete the chain of causation, we ought to have under the microscope, between the kidneys and the heart, and again between the heart and the brain, some of the minute arterioles from various parts, showing the muscular hypertrophy of their coats, demonstrated and explained so admirably by Dr. George Johnson. The successive links of the deadly chain would then run thus: Disease of the kidneys gave rise to accumulation within the blood of excretory materials which these organs should have eliminated; the circulation of the blood, thus rendered impure, was resisted by the stopcock action of the muscular coat of the minute arteries for the defence of the tissues; the heart, feeling this resistance, and not recognizing its conservative char-

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acter, began to act with increased vigour to overcome it, and carry on the circulation; while the arteries, on the other hand, contracted all the more energetically; and so, in obedience to the law that increased exercise of function by muscular fibre induces hypertrophy of structure, heart and arteries, in their strife one against the other, became hypertrophied. But when the heart is acting with increased power on the one hand, and the minute arteries are continuing their resistance on the other, the blood is at high pressure within the vessels; and if there is a weak spot anywhere the vessel will be in danger of bursting. This is what has happened in the present case, the weak point having been found in the small vessels penetrating the brain-substance from the middle cerebral artery in the posterior part of the Sylvian fissure.

The poor woman from whose body these morbid specimens were taken, was admitted under my care in September. She was for a time in the Alexandra ward, more recently in No. 2 bed in the Victoria ward, where some of you have repeatedly seen her with me, little anticipating from her appearance the sudden fate which has overtaken her. Her illness, according to her own account, dates from an attack of hemiplegia of the left side two years since, while pregnant. This seems to have been severe, as it was six months before she was able to walk about again. She got over her confinement, however, without any difficulty or complication. After regaining a fair state of health, she had within the last few months been complaining of weakness, loss of appetite, imperfect digestion of her food, discomfort after eating, etc.

She did not look particularly ill, and she presented no appearance suggestive of any special disease. Very slight traces of her old paralysis remained. Investigating the causes of her complaints, we came at once upon the fact that the urine contained albumen. This we might have suspected from the occurrence of hemiplegia during pregnancy. The amount of albumen varied considerably; there was never much, and sometimes it was absent altogether. The urine was pale, not perfectly clear, acid in reaction, and of a specific gravity of 1018, as a rule—never, so far as I know, below 1015—sometimes as high as 1020. Now this is a high specific gravity for the state of kidney we supposed to exist—contracted granular kidney—and at times cast a momentary doubt on the diagnosis. I account for it now by the fact that in one kidney the morbid change was still in an early stage. We obtained little microscopic evidence as to the kidney mischief—a few particles of damaged renal epithelium, and rare and questionable fragments of small granular casts. There was no trace of dropsy or œdema, and never had been; but in this particular affection of the kidneys we do not expect it, and, as I have said, there was no marked renal look.

But we had evidence from another source in favour of our diagnosis, the indirect evidence of the vascular system. I frequently pointed out to you the peculiar character of the pulse. On asking a student to describe it, the invariable report was that it was weak; and to the fingers placed lightly on the vessel that was the impression conveyed; there was, in effect, very little pulsatile movement in the artery. But then it was very large and very hard, and the vessel slipped and rolled about under the finger like a bit of thick whipcord, reminding one of the vas deferens among the structures of the spermatic cord, only much larger; and when it was attempted to control the pulsation by pressure with the finger nearest the heart, it was found to be a very difficult matter. Press as one would almost, the pulsation could still be felt by the two fingers on the distal part of the vessel. The first impression of weakness was thus at once removed, and the pulse recognized to be extremely strong; it was the long, hard, large pulse of high arterial tension, which gives a sphygmographic trace of gradual ascent, low elevation, rounded summit, and gentle, unbroken fall.

Then as to the heart: the area of dulness over it was extensive; its impulse was a powerful and widespread heave; the apex-

beat was conspicuously evident to both eye and hand below and to the left of its normal situation. This was of course evidence of considerable hypertrophy. A mitral murmur was reported to me by my resident medical officer when the patient was first admitted, but I did not succeed in hearing it: I thought I distinguished once or twice a smooth, feeble, systolic, tricuspid murmur; and a hæmic pulmonary murmur could sometimes be heard. I attached no importance to any murmur found to be present; but modifications of the heart-sounds of extreme interest were detected, namely, reduplication of the first sound over the inter-ventricular septum, extinction of the first sound, and exaggeration of the second over the aorta. These have recently been beautifully explained as phenomena of high blood-pressure by Dr. Sibson. To distinguish the reduplication, you must either have a double stethoscope and place one mouth over the right ventricle and the other over the left, or the common stethoscope must be planted over the septum between the ventricles. At the apex, or over the sternum, the first sound is pure and single; it is only when the sound given out by both the ventricles in their contraction is conveyed to the ear that a doubled sound is heard. This alone would suggest what is clearly brought out by manœuvring with the double stethoscope, namely, that the reduplication is due to the want of exact synchronism in the contraction of the two ventricles; that of the left is retarded by the extreme resistance to the entry of more blood into the already distended arteries, and thus the right gets a slight start. Each ventricle produces sound by its systole; and when, from any cause, the normal coincidence of the two is disturbed, the first sound of the heart, which is compounded out of the two sounds of the ventricles, is reduplicated. The diminution or extinction of the first sound over the aorta, again, is explained by the arterial tension, which prevents the left ventricle from throwing its contents rapidly into the aorta, and renders its action more gradual; while the increased pressure within the aorta, forcing back the semilunar valves with undue violence, causes the second sound to be louder.[1]

The high arterial tension so obviously indicated by the signs I have mentioned, which I repeatedly pointed out in my visits to the ward, and the cardiac hypertrophy, were corroborative of the diagnosis of contracted granular kidney. Another corroborative sign I looked for in vain: I mean the characteristic changes in the retina. My note of the appearances presented by the fundus of the eye on ophthalmoscopic examination is as follows: The fundus of the eye generally seemed paler than usual, the optic disc a little more pink; so that, though the disk was well defined, the difference between it and the surrounding retina was less marked than usual. It was small, had no appearance of elevation, and presented in the centre a white spot from which the vessels issued. The retinal artery seemed smaller than usual. No white spots or hemorrhages were seen.

The objects to be kept in view in the treatment of a case of this kind are simple and obvious. We cannot hope to undo the structural mischief already done in the kidney; in some cases we may perhaps arrest the morbid process when it is traceable to some known cause, as alcoholic excess, etc.; but, generally speaking, what we have to do is to avert, as long as possible the consequences—the accumulation of urea or other poisonous substances in the blood, and the loss of strength and deterioration of structure to which the state of the blood gives rise. The bowels must be kept open, the action of the skin must be encouraged, so as to secure whatever vicarious elimination their excretions may afford; the diet must be regulated and digestion aided; and it is generally beneficial to give the tinct. ferri muriatis. This was the line of treatment we followed, and our patient seemed

[1] The tension of the arterial walls is an element in the production of the second sound, but this and other points were not discussed. Nor is what has been said intended as a complete exposition of the relation of the modification of the sounds to the arterial tension: it was rather a reminder to students already familiar with Dr. Sibson's teaching.

decidedly better; she was relieved of the symptoms which caused her to seek admission; the reduplication of the first sound of the heart was no longer heard; the artery at the wrist was not so full and hard; once, indeed, for a few days during a brief pyrexia the peculiar character of the pulse was lost altogether; and it was expected she would soon leave the hospital greatly relieved.

The dangers to which the subjects of this form of Bright's disease are exposed are, on the one hand, uræmic poisoning, so called when the nervous system is affected, or secondary inflammation of important organs, or effusions into the great cavities, from disturbance of the normal relations between blood and tissue; or, on the other hand, rupture of a vessel in the head as a consequence of the great arterial tension. We had no special reason to anticipate any of these unfavourable effects immediately. The specific gravity of the urine seemed to guarantee the elimination of a fair proportion of the urinary constituents; the patient had not the well-known renal look; she was not old; there were no advanced retinal changes, and the arterial tension was reduced. There was, however, an element of danger, of which I was not for some time aware. The woman was five or six months pregnant. She stated all the time she was under observation that the catamenia were regular, and nothing had occurred to lead to a physical examination of the abdomen till shortly before her death, when she mentioned some uneasy sensation in the hypogastrium. I proceeded to see if any cause for this was to be found, and, coming upon the uterus, I said at once, "Why, you are pregnant." This the patient strenuously denied, repeating her statement that she had been quite regular, and was, in fact, menstruating at the time; saying, also, that the tumour I felt had been there for some time. She was a married woman and had no reason for concealing her pregnancy, unless, as it occurred to me since, she had apprehensions of danger attending it, which made her wish to blind herself to its existence; and I accepted her denial *pro tem.*, with the intention of making further investigation when the catamenial period was over. Now, without saying at all that the pregnancy was an important factor in the causation of the hemorrhage, the coexistence of pregnancy and albuminuria is a serious matter, which, had it been fully known to me, would have led me to look on the immediate future of the patient with more apprehension. But this is a point into which I cannot enter fully now, and we must come to the fatal attack, which was preceded, and perhaps determined, by two or three days of more than usually obstinate constipation.

At about 3.30 on the morning of Thursday, November 30, she was apparently as well as usual, and asked the night-nurse for drink. A few minutes later her right leg and hand were knocking against a screen which stood by her bedside. When the nurse went to her, the right limbs were thrown about, but more as if the movements were voluntary than convulsive, while the left limbs were rigid, contorted and twitching; the face was at first distorted. By the time the sister of the ward and the resident medical officer reached her, the movements of the right side were less violent; the face was equal on the two sides, but the rigidity of the left limbs was the same; the right pupil was greatly dilated, the left much contracted. The patient recognized both, and gave their names, but she could give no account of herself, or of what she felt. Later she was more quiet, but from time to time tossed off the clothes with the right hand or leg, and rubbed her head with this hand, while the left limbs remained rigid and powerless, and were at intervals shaken by a peculiar tremour; the left hand was powerfully pronated, and the fingers and wrist flexed; she resisted when the eyes were opened, seemed to resent disturbance, evidently felt a pinch on the right side, but gave no indications of sensation on the left half of the body; she swallowed fluids pretty well; no signs of consciousness beyond those first mentioned could be elicited. Soon after 3 P.M. convulsive movements again came on, and she died almost instantly. The tongue was bitten.

These details are chiefly interesting in

connection with the seat and extent of the hemorrhage. The clot lay to the outer side of the right corpus striatum and thalamus, and had torn through the fibres passing from them into the hemisphere. It extended along nearly the whole length of the ganglia, but did not turn round the anterior end of the corpus striatum. Its upper part was on a level with the intraventricular surface of these bodies. Inferiorly it was separated by a very thin stratum of nervous matter from the fissure of Sylvius, and, in my opinion, the source of the bleeding was the small branches of the middle cerebral artery here penetrating the brain-substance. Now, my interpretation of rigidity in the paralyzed parts at the onset of apoplectic hemiplegia is injury near, but not extensively or deeply involving, the motor ganglia or tract. Destructive lesion of the motor apparatus appears to leave the paralyzed limbs relaxed; pressure upon, or "irritation" of it, while its cells and fibres are still in continuity, appears to me to render them rigid. This view of mine may, of course, at any time be overthrown by facts inconsistent with it; but, at any rate, it has the support of this case, and I could give you many others.

One question remains: "Could anything have been done to postpone the fatal issue when once the rupture of the vessel had occurred?" I do not know, but had I seen the patient at once I should have bled her, simply on the ground of the antecedently known high arterial tension We can all see now that, at least, this would have done no harm. You will not, however, from this statement infer that I recommend or practice venesection in apparent apoplexy as a rule; the very contrary is the case, and on some future occasion I hope to show you reasons for this.

Looking once more at the morbid specimens, and taking a backward glance at the history of an attack of hemiplegia in a previous pregnancy, at the comparatively slight evidence of kidney disease offered by the urine and general appearance of the patient, and at the assistance to a correct diagnosis and warning as to the kind of danger to be apprehended afforded by attention to the signs of arterial tension in the pulse and in the modifications of the heart sounds, and remembering also, as I always shall, the existence of pregnancy at the time of the final apoplexy, you will find the case full of interest and instruction.

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Abstract of a Clinical Lecture on Death from Chloroform. By J. Eric Ericksen, Senior Surgeon to University College Hospital.

Thanks to the somewhat frequent occurrence of the heading "Death from Chloroform" in the papers, the subject is beginning to excite a considerable amount of interest and apprehension amongst the public. In the profession, there has been, I think, rather a tendency to avoid the subject—to look upon the occurrence of an occasional death from chloroform as a sort of necessary price paid for the advantages of anæsthesia. Whether this be the case, whether the fatal result really depend on an inexorable fate or on some more preventable cause, is, I think, worth inquiring into. Considering the extensive and general employment of chloroform for even the most trivial of surgical operations, a death directly due to its influence is, happily, of rare occurrence. During the twenty-five years that I have been attached to this hospital, I have only witnessed one such death. It is a sight which must always produce a deep and painful impression on those present; the more so, since the administration of chloroform is by no means a necessary part of the operation; the relief of pain is in many cases nothing more than a luxury.

All surgeons will agree with me that, in extra-hospital practice especially, the administration of chloroform is that part of the operation which often gives most anxiety to the operator. In a hospital, chloroform is generally administered by some one who is in the daily habit of performing that duty. The process is watched by competent observers, and there is every appliance at hand in case of need. In private practice it is often given by the practitioner in charge, whose only experience is derived from a limited use of the drug in midwifery cases, and both the pa-

tience and peace of mind of the surgeon are upset: for, indeed, a considerable amount of practice and experience are required to enable a man to give chloroform well; some acquire the necessary skill more easily than others; but no amount of care can make up for the want of a certain amount of practice.

We must confine our attention to deaths which are *directly and immediately* due to chloroform. These may occur is three ways—by the lungs, by the head, or by the heart; from asphyxia, from coma, or from syncope.

I. *Asphyxia* may be caused (1) by tight clothing, or by anything which hinders the respiratory movements, as a large abdominal tumour; (2) by actual choking. If chloroform be given too soon after a meal, vomiting of semi-digested material is very likely to occur, and the larynx may be obstructed by it. A gag or false teeth may slip into the throat and cause choking; the tongue, also, like the other voluntary muscles of the body, becomes paralyzed when the patient is fully anæsthetized, and, by falling back into the throat, may itself cause choking. Deaths from these causes, the first more especially, have occurred most often in dentists' practice. Still, simple asphyxia is not often actually fatal, though narrow escapes are common; the signs are so well marked that they can scarcely be overlooked, and the patient can generally be recovered if assistance be at hand.

II. Death from *coma* due to chloroform is rare; still, the only case with which I have been personally connected was due to this cause. The patient was suffering from chronic Bright's disease, and had slight symptoms of uræmia. The administration of chloroform had not proceeded far when convulsions occurred, followed by coma and death in about an hour. In this case, at all events, the mode of death was evidently predisposed to by the poisoned state of the blood.

III. We come at last to that part of the subject to which I wish more particularly to direct your attention—the death from *cardiac syncope*, as it is called. This is to me a very puzzling mode of death, as difficult to account for as it is to guard against. I presume that by the term "cardiac syncope" is meant atony and failure of the heart's action. This is an easy explanation, but not altogether a satisfactory one. Amongst the numerous experiments which have been made with chloroform, I do not know of any which prove that it has any direct syncopal action on the heart, or even any indirect toxic action on that organ through its nerves. Still there is no doubt of the fact, that people do die without much disturbance of respiration, without becoming distinctly livid in the face; the pulse fails; that is the first thing noticed, and they are dead.

Now, my own idea is, that these are really cases of asphyxia; that the heart is secondarily, not primarily, affected; and my explanation would be as follows. After death we find in these cases a weak, fatty heart; the valves, indeed, healthy, but the walls thin, and the muscular tissue pale and degenerated. Now, chloroform has always, especially at first, a slight asphyxial tendency; the patient calls out that he is choking, tries to pull away the inhaler, and breathes deeply, then struggles and holds his breath for a few seconds. In a healthy man this soon passes off, the inconvenience is merely temporary; but with a fatty, enfeebled heart, it is different—the patient holds his breath for a few seconds, the right side of the heart is soon filled, there is weak propulsive power, the organ cannot recover itself, and the result is fatal.

Some years ago, I made numerous experiments on death by asphyxia in animals; and I found that if once the ventricular action were stopped, if a contraction were missed, it was most difficult to start again—generally all was over. And this is what happens in these cases; the ventricle cannot be emptied quickly enough, the rhythm is lost, and almost instantaneous death ensues. The patient, then, does not die from the direct action of the chloroform on the heart, but from the effect of a slight asphyxial condition, which is inseparable from the administration of this agent on a disorganized heart. After death, you may not find the right side of the heart greatly engorged; first,

because great engorgement is not necessary to cause a fatal result; and, secondly, the blood, even many hours after death from chloroform, is found unusually fluid, so that the dependent parts of the body are congested and the heart is left comparatively empty. Then, also, artificial respiration is always set up in these cases, and this tends to diminish the cardiac plethora.

Finally, a few cautions. Never give chloroform without first thoroughly loosening the dress; if possible, not within four hours of a meal; the head should be moderately raised; the pulse, respiration, and colour of the face, must be carefully watched. As regards the occurrence of the rigid spasm already adverted to, I do not think that sufficient attention has been directed to this condition. A patient with an enfeebled heart is then in a most dangerous, even critical, state; the chest-walls are fixed, the lungs are filled with chloroform-vapour, which becomes diffused but cannot escape, the pulmonary circulation is obstructed, and the pressure on the right ventricle rapidly increased. Let the patient partially recover, then give it again slowly; watch for any blueness around the mouth, etc. If the pulse fail, draw forward the tongue with forceps, and set up artificial respiration at once; but prevention is the main point. When there is well-marked asphyxia, artificial respiration is most useful, and generally successful; but in these cases of so-called "cardiac syncope," it is generally useless; the heart has been barely able to meet the ordinary requirements of the system; it cannot recover lost ground; it gives in, as it were, at once.—*Brit. Med. Journ.*, June 8, 1872.

HOSPITAL NOTES AND GLEANINGS.

Operations by Sir Wm. Fergusson at King's College Hospital.—Amputation of the Hand at the Wrist.—Sir Wm. Fergusson exhibited a man with an excellent stump, after amputation at the wrist, where the processes of the radius and ulna had been left. He advised that these processes should not be sawn off when healthy, as the breadth of the stump at the end of the arm was useful rather than otherwise.

Vesico-vaginal Fistula.—Ten days before, Sir William Fergusson had put in three stitches, with the hope of completely closing the fistulous opening. It had originated in the vaginal operation for stone nine years before. At that time, the healing process failed, and the operator had not again closed the wound. The patient was very young when operated upon for stone, and it was not easy then to stitch the wound. Sir William Fergusson saw her some time ago, and advised her to come into the hospital, in the hope of closing the wound by suture; but the operation has been partly unsuccessful. To-day the girl said that the parts were quite dry, and on that supposition he proceeded to take out the stitches; but she had not given a correct account of herself, for urine was dribbling freely through the wound. He removed the stitches, but thought it unadvisable to do anything further then to the wound. He said that three or four operations were sometimes necessary in a case of this kind, just as for cleft palate.

Dislocation of Astragalus.—A man came into the hospital in consequence of having injured his ankle by a fall. The astragalus was dislocated outwards, and there was a good deal of effusion about the joint. On first looking at it, Sir William Fergusson thought that there might be a fracture; but as he could not freely manipulate the parts when the man was under chloroform, he concluded it to be a dislocation. He attempted its reduction with the aid of three or four assistants, but was unsuccessful. He then divided the tendo Achillis and made the same trial, but again failed. What was next to be done? He thought he would not be justified in removing the astragalus, and therefore determined to place the foot on a straight side-splint. He had seen tolerably good and useful feet after such a displacement, particularly if no violent inflammation set in, disorganizing the joint, and he hoped this would be the case with the present patient.

Aneurism at Base of Neck.—For this aneurism, Sir William Fergusson had tied

the subclavian artery on May 25, five days ago. All had gone well till to-day after dinner, when a sudden gush of blood from the wound occurred. Mr. Rowe, the house-surgeon, immediately came to the assistance of the patient, and succeeded in stopping the bleeding by putting strong pressure on the wound. What seemed peculiar in this case was, that the usual time for secondary hemorrhage had not arrived. Had this been the ninth or twelfth day after the operation, it would not have been out of the ordinary course of things; but as it was only the fifth day, the hemorrhage could not be looked upon as simply secondary. There have been several cases of secondary hemorrhage following in succession in this hospital. In the case of a lad with a wound in the lower part of the thigh, there was repeated formidable bleeding; and the superficial femoral artery was about to be tied when it ceased, and he went on favourably afterwards. A few weeks ago, Sir William Fergusson took out some dead bone in the same locality, where there was great risk to the popliteal vessels. Great secondary bleeding came on, and only stopped after several stuffings of the wound. A girl, also, from whom he removed a tumour under the sterno-mastoid muscle, had profuse bleeding, of an apparently venous kind, coming from the great vessels at the root of the neck; and her case is now very critical, it being a question whether the wound should not be reopened and the internal jugular tied. In the mean time great pressure checks it, and Sir William thinks it most to be trusted.—*Brit. Med Journ.*, June 8, 1872

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Excision of the Knee-joint for Gunshot Wound; Recovery.—Excision of the knee-joint for gunshot injury has proved so notoriously unsuccessful in military surgery, that authorities on the subject are generally disposed to condemn it. An exception to the general rule of fatality has, however, been recorded by Dr. E. Ritzmann, of Berlin, in the *Berliner Klin. Wochenschrift* for June 3. The case was that of a Prussian soldier, aged 24, who was shot through the right femur, close above the knee, at the battle of Gravelotte, on August 18, 1870, and on October 13 was brought to Berlin in an ambulance train, under the guidance of Professor Virchow. Considerable suppuration set in, attended with severe remittent fever; and, on November 9, the joint was excised by Dr. König. The limb was put up in plaster of Paris, the joint being left exposed, and a drainage-tube being inserted to allow the escape of pus. The progress of the case after the operation was remarkably favourable, there being only temporary febrile disturbance in December and January; and, when the patient was discharged on May 23, 1871, there was complete ankylosis of the limb in a slightly bent position, with shortening to the extent of $2\frac{1}{4}$ inches. On September 26, the patient gave a favourable account of his condition.—*Brit. Med. Journ.*, June 8, 1872.

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Severe Chronic Rheumatism mistaken for Disease of the Spinal Cord. By J. Lockhart Clarke, M.D.—J. B., æt. 33, for eight years on police force, was compelled to leave in consequence of protracted illness. Eleven years ago he had chancre, but no secondary symptoms. During his service in the police, he frequently got severe colds, sometimes in consequence of rain dripping from the edge of his cape on to his loins and the back of his knees. About two years ago, he began to feel very severe pain across the loins and along the spine, accompanied at first by severe and obstinate vomiting. The pain in his back was constant, night and day, and for some time he was quite unable to bend forward. On getting better, he continued on duty for about three months, during which he was under the care of the divisional surgeon, who cupped him on the back and prescribed for him, but without relief. Some time afterwards he went into one of the metropolitan hospitals, where he had blisters and actual cautery to the spine, hypodermic injection of morphia, warm baths, and medicine. After a month of this treatment he left the hospital unrelieved, with severe pain, weakness, and numbness and trembling of the legs. During the next three months he was un-

der the care, first of the divisional surgeon, and then of another practitioner, who used the hypodermic very freely, but with only temporary relief.

When I saw him a few months later, he was pallid and emaciated, complained of pains along the legs, with trembling on standing, some numbness of the feet, and severe lumbar pain with stiffness, which prevented him from standing erect. The pains were incessant night and day. I prescribed for him the following draught, to be taken every four hours. ℞ Potassii iodidi gr. x; aquæ camphor. ℥iss; spir. chloroformi ℥ss. He had no applications to the back. On seeing him two days afterwards, he told me that for the first time during the last two years he was almost entirely free from pain, and felt himself nearly well, with the exception of weakness. He continued the same medicine at longer intervals, and before the end of a week not a vestige of pain remained. He then took nitro-hydrochloric acid with some bitters, and entirely recovered his health and strength. For more than two years he has kept a public-house in Rochester Row, Westminster, and has never had any return of his complaint, except on catching cold, or indulging too freely in drink, when he has always resorted to the same medicine with unfailing relief.

Although his case, as the patient told me, had been considered as an affection of the spinal cord, there can be no doubt that it was one of protracted and deep-seated rheumatism, affecting the ligaments of the spinal column, and involving the sheaths of the spinal nerve-roots, complicated perhaps with syphilitic taint, as the early history of the case, and the very remarkable success of the treatment might lead us to infer.—*Brit. Med. Journ.*, May 4, 1872.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Rapid Death from Stings of Bees. By J. O. Sanders, M D., Carrollton, Mississippi. —April 18, I was called to a plantation two miles distant to see a patient stung by bees. Mr. S., an intelligent man, gave the following account. Louis ——, a negro, aged about 45, climbed a tree where bees had swarmed on a limb, for the purpose of hiving them, carrying with him a saw. As soon as the limb commenced falling, the bees arose *en masse* and covered his head and face. He descended immediately, and, as soon as he reached the ground, commenced running as fast as he could; ran around three sides of a yard, some two hundred steps, passed through an open gate and fell to the ground. Mr. S. ran to him with a bottle of spts. camphor, and succeeded in forcing him to take one swallow, the patient protesting at the time against assistance, declaring that he would certainly die. After two or three irregular and partial respirations he expired. Mr. S. thinks it could not have been more than five minutes from the time he was attacked by the bees before he breathed his last. When I arrived, about an hour and a quarter after the accident, I could, on careful examination find no signs of life. He was a vigorous, muscular man, and in perfect health, so far as I can learn. Was death due, in this case, to direct nervous shock, or to absorption of virus, or both?

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Morphia and Chloral in Combination. By R. H. Fisher, M.D., of Kennekuk, Kansas.—For the last year I have used morphia and chloral combined, with the best results. A single example will illustrate this. Last winter I was called up late one night to see a fellow practitioner suffering intense agony from rheumatism. His wife had already given him about a grain of morphia without relief. I immediately administered ten grains of chloral, and in ten minutes he was free from pain.

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Cotton Wool as a Surgical Dressing.—Dr. Wm. Warren Greene, Professor of Surgery in the Medical School of Maine, states (*Boston Med. and Surg. Journ.*, May 23, 1872) that for the last five years he has used cotton wool almost exclusively as a dressing for wounds where he desired or expected union by first intention, and that Prof. Robinson, of Portland, has also used it for many years. Prof. G. prefers the French wadding which is made

of the purest cotton, and for the employment of which he acknowledges himself indebted to Prof. R. After quite an extended observation of its merits as a light, neat, elastic dressing, simple and easy of application, and especially agreeable to the patient as compared with other appliances, and finding that, apparently, the healing process under its influence was remarkably rapid and favourable, it occurred to him that there must be some other quality operating than those mentioned which contributed to the, sometimes, wonderful results; and this quality he regards as its capability of filtering the air of all spores or germs. With this view he has extended its use to the treatment of abscesses and suppurating surfaces, as well as to that of simple incised wounds. "I feel very sure," he says, "that any surgeon, having once given it a fair trial, selecting a pure, nice article of wadding, will never use any other dressing for simple incised wounds; and while I attribute much to the lightness and *elasticity* of the material, through which we secure, with comfort to the patient, equable, elastic pressure over the entire surface, I am inclined to attach great importance to its action as a filter." "In all cases," he adds, "of recent wounds dressed with cotton wool, when the compress was so carefully applied as to exclude air around the edges, whether the wounds were closed or open, incised or lacerated, we have never seen a drop of pus upon raising the compress the first time. When oozing has occurred, we have found the cotton coated with dried blood and lymph, but no *pus*.

"I may state, parenthetically, that after such a dressing I am very slow to disturb the dressing so long as no symptoms of inflammation are developed. Avoiding, if possible, all lotions, fomentations, or anything of the sort, I am anxious to retain the primary dressing as long as practicable."

This mode of dressing wounds is identical with that adopted by M. Guerin (see No. of the *American Journ. of Med. Sciences* for Oct., 1871, p. 561) and the explanation of its *modus operandi* given by both is the same. Who has the priority in the use of this dressing we are unable to say, but M. Guérin has undoubtedly the priority of publication, and the statements of both are valuable as confirmatory of each other's results.

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University of Louisiana.—The following changes have been made in the Faculty of the Medical Department. Prof. Warren Stone has resigned the chair of Surgery, and Dr. T. G. Richardson that of Anatomy. The latter gentleman has been transferred to the chair vacated by Dr. Stone, and Dr. Samuel Logan, late of the New Orleans School of Medicine, has been elected to fill the Anatomical chair rendered vacant by the transfer of Dr. Richardson.

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Bureau of Medicine and Surgery U. S. Navy.—Dr. James C. Palmer has been appointed chief of this Bureau in place of Dr. J. M. Foltz, retired from active service.

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Boylston Prizes.—At the Annual Meeting of the Boylston Prize Committee, held June 3, 1872, a prize of $200 was awarded to J. Collins Warren, M.D., of Boston, for the best essay offered on the subject of "The Pathology of Malignant and Semi-Malignant Diseases." A prize of $150 was also awarded for the best essay on the "Pathology and Treatment of Sunstroke," to Dr. Horatio C. Wood, Jr., of Philadelphia.

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Mortality from Smallpox in Philadelphia.

During the week ending June	1	. . .	41
" "	" 8	. . .	24
" "	" 15	. . .	19
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FOREIGN INTELLIGENCE.

Early Calculous Disease and its Treatment.—Sir Henry Thompson (*Lancet*, Jan., 1872) confining his remarks to the uric (chiefly) and oxalic varieties, regards the tendency to calculous disease as hereditary. A uric acid deposit becomes of importance only when it is persistent. Gravel and gout alternate in generations, or in the same individual. Uric acid and gouty symptoms are due to weak liver

(part of its work being handed over to the kidneys) and feeble intestinal action. Potash, and the alkalies generally, merely dissolve the uric acid for the time being. It is still there in excess. The best treatment is gentle purgation by mineral waters (Friedrichshall and Carlsbad being the best). The diet should be sparing. It should include no alcohol in any shape, and as little as possible of fatty and saccharine matters.—*Birmingham Med. Rev.*, April, 1872.

—

Addison's Disease.—Prof. Béhier has delivered, at Hôtel Dieu of Paris, a long and learned lecture on the above disease. He concludes that much obscurity still exists respecting the histology and pathology of the suprarenal capsules; and that it is not proved that in those bodies resides the power of developing the bronze skin. He would be inclined to say that the pigmentation just named may accompany every decided state of cachexia.—*Lancet*, June 8, 1872.

—

The Treatment of Hyperæsthesia of the Vulva and Vagina. — M. Guéneau de Mussy (*Gaz. des Hôpitaux*, June, 1871) is strongly opposed to the treatment adopted in vaginismus, by Sims, and he thinks that a wise combination of therapeutic agents, together, if need be, with progressive or sudden dilatation, will often render resort to deep incisions unnecessary. He has often obtained the most happy results from the action of vaginal suppositories:—

Cacao butter	2 gram.
Bromide of Potassium . .	30 centigr.
Extract of Belladonna . .	10 "

This suppository he introduces every night, and its use is continued for two or three weeks.—*Birmingham Med. Rev.*, Jan. 1872.

—

Guarana as a Remedy for Sick Headache.—The Guarana (*Paullinia sorbilis*) is a favourite remedy in France for sick-headache and various forms of neuralgia, and is gaining some favour in Germany and in this country. Recently Dr. Wilks and Dr. Latham have called attention (*Brit. Med. Journ.*, April 20 and 27, 1872) to it in England. "The seeds, roasted, bruised, and pressed into cylindrical masses, constitute the guarana paste, which, when finely pounded, is then known by the name of Paullinia powder. This is light brown in colour, has an odour faintly resembling roasted coffee, and a bitter astringent taste. It contains, in addition to empyreumatic oil (developed by the process of roasting) and tannic acid, guaranin, a substance identical in composition with caffein. The large proportion of tannic acid in its composition renders its action very efficacious as an astringent; whilst, owing to the guaranin, it has much the same effect on the nervous system as tea or coffee."

It is given in powder in doses of ten to fifteen grains or more, once or oftener in the day, either mixed with water or sugar. In some cases it relieves very promptly. Dr. Wilks says, in some instances it acted like a charm, in others its effects were doubtful, and in others it entirely fails. The article can be obtained in this city from Mr. Frederick Brown, N. E. corner of Chestnut and Fifth Streets.

—

Condurando in Cancer.—Two cases of cancer treated by condurando in the Bradford Infirmary, England, are reported in the *Brit. Med. Journ.* (May 18, 1872). In one the drug had no effect, and in the other the cancer extended more rapidly during its use.

—

Salts of Quinia.—MM. Chauffard and Briquet, and some other members of the French Academy of Medicine, maintain that the tannate of quinia is inert, while M. Mialhe thinks it exerts some influence but at the same time he pronounces it to be a detestable salt. With regard to the sulphate of quinia, he says it "should never be employed as a basic sulphate, but as an acid salt. In this acid state the sulphate may compete with all other salts the base of which is quinia; for it should be noticed that it is the quinia itself, and not its saline combinations, which acts. The acid only serves as a vehicle for the introduction of the quinia into the blood; in the latter the quinia is set free by means of the alkaline or earthy bicarbo-

nates which the blood contains, and then its modifying action begins. It is a mistake to believe that the sulphate of quinia, when this salt is administered, can be traced in the urine; the salts traced are the acid phosphate of quinia associated with the phosphates of lime and magnesia."

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Medicinal Uses of Oil of Amber.—Mr. T. T. Griffith informs us (*Brit. Med. Journ.*, April 20, 1872) that a patient, in rapidly declining, suffered from constant hiccough for two or three days, and, at the advice of an old practitioner, he gave five drop doses of oil of amber, with as much liquor potassæ and laudanum, and the relief was immediate and complete. "In my own hands, and those of my medical friends," he says, "oil of amber has been an unfailing remedy, and at this time is the only means of arresting an exhausting hiccough in a patient dying of chronic vesical catarrh. I suppose that it formed the basis of Roche's embrocation—by no means a contemptible remedy in whooping-cough; and I have seen much good from its administration in the advanced stage of the disease. In the chronic state of eczema on the scalp and surface generally, its free application has been of marked benefit. It had also served me in good stead in a case of distressing cramps of the extremities. The patient, while on a temporary visit to the country, was, for the latter weeks of pregnancy, nightly tormented with severe cramps in all the extremities, obliging her to have an attendant in her room to change her posture or rub the limbs. Ordinary remedies, local and general, had no effect; and, believing that the oil of amber did in a great degree control muscular spasm, I gave the patient the medicine with the effect of stopping the spasmodic contraction of the muscles. In her case, its beneficial effects were very marked. The combined drugs, apart from the oil of amber, had no salutary effect whatever. In the *Pharmacopœia* of 1809, it was introduced, combined with ammonia, as "spiritus ammoniæ succinatus." The mixture taken by the lady was as follows; ℞ Olei succini ʒss; liq. potassæ ʒj; tinctur. camph. comp. ʒss; aquæ menthæ piper. ad ʒvi. M.: an ounce to be taken at bed-time.

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Tetanus following Hypodermic Injection of Quinia.—Surgeon Odevaine reported (*Indian Med. Gaz.*, April, 1871) a case of tetanus following the hypodermic injection of quinia, and in the No. of the same journal for May, 1872, two more, which occurred in the jail hospital. In these two cases the injections were given by a native doctor, who states that the quinia was given in a perfectly clear solution. An abscess formed at the site of puncture in a few days, and both men died within twenty-four hours of the first appearance of tetanic symptoms.

Surgeon O. states: "In the cases in which I have myself employed the neutral quinia, dissolved in distilled water, in the proportion of 4 grains of the former to 40 minims of the latter, no irritation has resulted. I think it but right to make known the fact that tetanus does occasionally occur as a result of the hypodermic use of quinia, and to record my opinion that this medicine should only be employed subcutaneously, when its administration by the mouth or rectum is, owing to great gastric irritability, or the presence of diarrhœa, inadmissible.

—

Diabetes produced by Oil of Turpentine.—Almen (*Neues Jahrb. der Pharm.*, xxxiv. p. 113) found sugar in the urine of several patients after they had taken 100 drops of oil of turpentine. It disappeared on the day after the medicine had been discontinued. It was not produced by copaiba or by cubebs.—*Brit. Med. Journ.*, May 11, 1872.

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The Aspirator in Surgery.—M. Labbé, a young surgeon and *agrégé* (sub professor), has been doing wonders with the capillary or aspiratory trocar—the instrument patented by Dieulafoy, of Paris. M. Labbé informed me, while on a visit to the Hôpital de la Pitié, that he had, the previous evening, punctured the bladder above the pubis of an elderly gentleman who was suffering from retention of urine resulting from an enlarged prostate. This was done with the above-named instru-

ment, and 700 grammes (about 22 ounces) of urine were drawn off at one sitting. Several ineffectual attempts had been made to introduce a catheter, which ended in making a false passage towards the rectum. M. Labbé prefers Dieulafoy's trocar to the other methods in vogue, as being perfectly innocuous, the wound healing immediately. He had performed the same operation several times—both in his nosocomical and private practice, and intends submitting his observations to the Academy of Medicine. A very interesting thesis has been written on the subject by Dr. J. Watelet. In the case under notice, M. Labbé was to relieve the bladder in this way once or twice in the twenty-four hours, according to the urgency of the symptoms; and that he will repeat daily until the wound in the urethra is healed, when he will resort to other means for the removal of the cause of the retention of urine. I may here observe that many surgeons already predict one great disadvantage in this new method—not to the patients, but to the future generation of surgeons—as catheterism, which even nowadays is so little confided to students, would run the risk of being altogether put aside. This capillary or aspiratory trocar, intended at first only as an exploring instrument, was not much larger than an ordinary urethra-syringe. This was gradually increased in size, and was then employed for opening large abscesses and cavities containing liquid. M. Collin, successor to Charrière, has still further improved the instrument, in such a way that it may be used not only for emptying abscesses and cavities, but for washing out or injecting these, and it is of a size containing from 120 to 160 grammes that these operations may be performed without deranging the instrument. This new trocar is, I think, destined to render great service both in medicine and surgery; and it struck me that it would be preferable to the ordinary lancet in venesection, as the risk of air entering the vein is *nil*, in which case the needles would of course have to be made a little thicker, so as to have a good and uninterrupted flow, and the ligature above the elbow may be dispensed with.—*Med. Times and Gaz.*, May 4, 1872.

Inoculation of Tuberculous Matter in the Human Subject.—Messrs. Paraskeva and Zallonis, of Syra, in Greece, have published in the *Gaz. Méd. de Paris* (April 27, 1872), an account of five experiments on rabbits, wherein tuberculous matter, either mixed with the food or inoculated, excited deposits of the same kind in the lungs, thus confirming Villemin's investigations. The authors attempted besides a bolder experiment, and inoculated a fisherman of fifty-five years of age with tuberculous matter on the upper part of the thigh. This man was suffering from gangrene of the great toe, in consequence of obliteration of the femoral artery. He steadily refused amputation, and the authors considered themselves justified in undertaking the experiment. The patient died thirty-seven days after the inoculation, and had never been ill before in his life. Seventeen tubercles in the first stage of development were discovered in the apex of the right lung; two were of the size of split peas, and the others as large as mustard seeds. Two more tubercles were observed in the apex of the left lung. The liver looked healthy, but presented two tubercles on its convex surface of the size of peas. The authors conclude that they have proved their point, but it should be recollected that, in ordinary autopsies, tubercles are often found when their existence from the history could hardly have been suspected. As for animals, it may always be asked whether we can, in all cases, conclude that the phenomena observed upon them would be the same upon man.—*Lancet*, June, 8, 1872.

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Chemical Composition of Pus.—Hoppe-Seyler (*Med. Chem. Untersuch.*, 1871, 486–501) has obtained results which are interesting in reference to the question of the origin of the pus-corpuscles and their identity with the colourless and lymph corpuscles. He introduced fresh crystalline lenses of the ox into the abdominal cavity of dogs, and analyzed them after a period varying from one to fourteen days. As was expected, the lenses became infiltrated with lymph-corpuscles. Glycogen was found in greatest abundance at the eighth day, at which period they con-

tained the greatest number of contractile corpuscles. The glycogen is due to these corpuscles. If the lenses were not plunged immediately into boiling water, but allowed to stand for some time, no glycogen was found, but in its place sugar. In the pus of congestion-abscesses, no glycogen occurred. The occurrence of glycogen, therefore, may be taken as a means of distinguishing lymph from pus-corpuscles. When glycogen is found in abscesses, it will be found to coexist with the presence of numerous contractile corpuscles. Lymph-corpuscles, therefore, by their transformation into rigid pus-corpuscles, become deprived of their glycogen.—*Brit. Med. Journ.*, May 25, 1872.

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Chloralum and Preparations of Chloralum as Disinfectants.—Prof. A. Fleck, Director of the Central Chemical Institution established at Dresden for the protection of the public health, has made a thorough investigation of the composition and value of these products, and with the following results:—

1. The preparations of chloralum have nothing in common with the similarly sounding chloral hydrate, and are, in point of fact, mixtures of chloride of aluminium. 2. The preparations of chloralum contain chlorine combinations of lead, copper, and arsenic, which renders their employment not free from danger, and which would render their employment as a medicine or as an astringent for open or suppurating wounds dangerous. 3. The price of the preparations of chloralum bears no relation either to their nature or their effect. Considering that the liquid chloralum yields a clear profit of at least 700 per cent., and the wadding 400 per cent., the limits of honest trading may be considered as overstepped. 4. The result of these experiments is that chloralum and the preparations made from the same must be classed among the worthless arcana, and in the interest of the public health, as well as in the material interests of the public, a most decided warning must be given against the purchase of the same.—*Amer. Journ. of Pharm.*, June, 1871, from *Chem. Rev.*, March, 1872, and *Industrie Zeitung.*

On the Relative Power of Thirty-four Substances to prevent the Development of Protoplasmic and Fungus Life, and in arresting Putrefaction.—Dr. Crace Calvert read a paper (Feb. 20th last) on this subject before the Royal Society. The substances under examination were classed under the following heads: acids, alkalies, chlorine, sulphur, phosphates, tar, sulpho-carbolates, and miscellaneous. By experiments extending over many months it was ascertained that the acids, among which are named nitric and sulphuric acid, retard vibrionic life, while they allow fungi to appear soon. In the alkali group there is no prevention of vibrionic life, although in the case of lime its development took thirty, and in the case of soda twenty-three days. Among the combinations of chlorine fungi appear late, vibrios not at all, at least not within eighty days. The author mentioned that Dr. Duvergie, Inspecteur-Général des Cimitières de la France, prefers, for the purpose of preserving corpses for inspection, letting water trickle on them constantly, to using bleaching powder, which, in his estimation, only accelerates putrefaction. None of the constituents of the sulphur group prevent fungous or vibrionic life. The same with phosphates. In turpentine vibrios appeared after forty and fungi after forty-two days. In sulphate of quinia vibrios appeared after twenty-six days, but no fungi during the entire period of the experiments. The author, in connection with this fact, called attention to the theory of the fungus developed in the blood in the case of intermittent fevers. On the whole, it was found that, in accordance with these experiments, the thirty-four substances can be grouped as follows: 1. Those which prevent the generation of fungi and vibrios—viz., cresylic and carbolic acid. 2. Those which prevent the development of vibrios, but not that of fungi; such are bichloride of mercury, chloride of ziuc, etc. 3. Those which prevent fungi, but not vibrios, to develop—viz., sulphate of quinia, pepper, etc. 4. Those which prevent neither the one nor the other. From his experiments as to the power of destroying microscopic life, by the addition of these substances.

Dr. Calvert found none thoroughly efficient.—*Lancet*, March 30, 1872.

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Confession no Proof of Guilt.—The *Lyon Médical*, of April 28, 1872, refers to the case of a girl, aged twenty, supposed to be seven months pregnant. After an attack of hemorrhage her size seemed to have considerably diminished, and the girl, being closely questioned on the subject, said that, becoming aware of the discharge, she repaired to the closet, where she stayed ten minutes. She added that all had escaped, but that she had not time to look, as she was being called by her mistress. A midwife and the parish surgeon both declared that the girl had been recently confined. She was now again assailed with questions, and told that, for her own sake, she had better make a clean breast of it, as no fœtus had been found in the closet. Perhaps, it was suggested, she had thrown it into the pigstye. The poor creature at first denied such a thing, but at last confessed that it was so. A search was made, but no child was discovered. She was tried for concealment of birth, on her own confession, and sentenced to six months' imprisonment. The girl had not been taken into custody in consideration of her free confession, and she quietly proceeded to the gaol. When admitted it was found that she was far advanced in pregnancy, and soon gave birth to a healthy girl. By the French law she could no longer appeal, as more than ten days had elapsed since the verdict; but the judge, having the power of appealing within two months, did so, and the girl was acquitted.

This case shows that confession, which is looked upon as the clearest proof of guilt, cannot always be relied upon. And what shall we say of the surgeon and the midwife? The examination was probably hurried and incomplete, and the conclusion arrived at on seeing the signs of recent abundant hemorrhage. This case, even in a simple obstetrical point of view, is full of valuable hints.—*Lancet*, May 18, 1872

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One Source of Skin Disease.—A correspondent of *Nature*, who signs himself "R. M." states that he has satisfied himself that certain attacks of eczema of the face to which he was formerly liable were due to the use of impure soap for shaving purposes. He declares that the "prime old brown Windsor soap" of the perfumers' shops is chiefly manufactured from bone grease. This, as extracted from the bones by the action of boiling water under pressure, is of a dark tarry brown colour, and of an abominable odour. By various processes it is more or less defæcated, bleached, and deodorized, and is separated into two or three different qualities, the most inferior of which goes to the formation of railway or other machinery greases, whilst the better kind is saponified and highly perfumed. The natural brown colour of the grease gives it the right tint in the cheapest way without the colouring by caramel, which was the original method of manufacture. Some bars of brown Windsor soap contain a rich admixture of small, sharp, angular fragments of bone, which, before boiling, were putrid. "R. M." states that, on three separate occasions, shaving with such soap, whilst he was otherwise in perfect health, induced an attack of eczema, which resisted medicinal treatment but disappeared on ceasing to use the soap.—*Lancet*, April 27, 1872.

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Bread made with Sea-water.—M. Rabuteau calls attention to the importance of this article. In the first place it is very pleasant eating, also increasing the appetite and stimulating digestion. On board ship bread so prepared has been found very conducive to the preservation of health during long voyages. It also exerts important medicinal effects, especially in dyspepsia. In phthisis and in scrofula the author states it is a powerful adjuvant.—*Med. Times and Gaz.*, Feb. 3, 1872, from *L' Union Med.*, Jan. 6, 1872.

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Obituary Record.—Died March 13, 1872, after a long and painful illness, aged 63, M. Michel Lévy, Grand Officer of the Legion of Honor, formerly President of the Academy of Medicine, and one of the most eminent of the French military surgeons

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Tracheotomy. By JOHN WOOD, F.R.S., Surgeon to King's College Hospital.

GENTLEMEN: Since we last met, before the Christmas vacation, there have been one or two cases requiring tracheotomy in the wards of the hospital. As this operation is usually called for on an emergency, it seldom happens that the whole class have an opportunity of seeing the conditions which demand the operation, or of estimating the manner in which it can be done most expeditiously and safely. The spectators of the operation are mostly those who are employed in continuous offices in the hospital, with some whose constant and steady zeal for practical knowledge overcomes the tendency to absent themselves from the hospital except when their presence is expected on stated occasions. Yet it is not the less desirable on that account to lay before you as a class the reason why, and the manner how, an operation so important and so frequently called for should be performed. It is one which all of you who practise your profession will at some time or other be called upon to perform. And it must usually be performed urgently, immediately, and with a decision which can only be properly obtained by a premeditated consideration of all the possible contingencies that may arise, of all the instruments that may be required, and with a fair knowledge of the anatomy of the parts concerned.

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In the first place, I must premise that there are no less than three operations for opening the windpipe in cases of obstruction to the respiration in this part of the respiratory passage, each of which possesses advantages that render it the most properly applicable in certain circumstances. These I propose briefly to lay before you in this lecture. To enable you the better to understand why they are severally more fitted we must consider the operations themselves and the site in which they are performed.

The operation of *laryngotomy*, as being placed the highest in the tube, and as the most simple, I will take first. It is performed in the crico-thyroid space by dividing the thin but tough and elastic membrane which connects the inner surface and lower border of the thyroid with the outer surface of the cricoid cartilage. This space is placed immediately below the true vocal cords, and of course below, or to the lung side, of that important strait or movable gateway through which we inspire the breath of life. Now the true vocal cords have a character in reference to the mucous membrane that covers them which has an important bearing upon the limitation of morbid affections of the larynx and trachea. The membrane which covers their highly elastic fibrous structure is very closely adherent to its substance. Above them the mucous membrane of the larynx is much more loosely connected by a submucous areolar tissue, which is apt, when inflamed, to swell up so as to overlap and overhang the chink of the glottis and obstruct respiration in this manner. It is also more liable to the ulcerative processes common in syphilis and phthisis, as well as to the spread of traumatic, erysipelatous, or diphtheritic inflammation from the mouth, fauces, and pharynx. Foreign bodies passing from the mouth, if irregular or pointed in shape, or somewhat soft in structure, are liable to become impacted in the same situation; and, lastly, tumours more frequently grow from the walls of the larynx or its marginal structures at a level above the vocal cords.

The close proximity of the crico-thyroid space to the rima glottidis enables the surgeon readily to open up the interior of the larynx by dividing the thyroid cartilage vertically, should the nature of the obstruction require it, or to pass instruments through the chink of the glottis to dislodge impacted bodies. Many of these are advantages which can often not be appreciated before the operation is commenced, and in the proper choice of a position is embraced the capability of meeting an enemy in various and unexpected combinations. Perhaps an advantage which would be reckoned by many as greater than any of these is the important one that this operation is much more simple, less dangerous, and more quickly and readily performed, in cases of impending suffocation, than any other upon the windpipe; and it is one which may be performed by almost any bystander with ready nerve, decision, and a tolerably sharp penknife. The crico-thyroid space is very superficial, placed at the most forward part of the curve of the trachea, immediately below the projection of the thyroid cartilage called the "pomum Adami." Below this point the windpipe pursues a backward and downward course, receding rapidly from the surface, while the outline of the neck is sloped considerably forwards down to the sternum by the sterno-mastoid and other muscles, and by the interposition of the thyroid gland. In the median line the membrane is covered only by the skin and fascia, but on each side the crico-thyroid muscles diverge from their origin to their insertion into the thyroid cartilage, so as to leave a triangular interval, with its base upwards, uncovered by muscle. Further out are placed the sterno-hyoid, thyroid, and thyro-hyoid muscles, which need scarcely be touched in the operation. A very small branch of the superior thyroid artery crosses the space to anastomose with its fellow, giving off on each side a very small twig through the membrane, called the anterior laryngeal. You see, therefore, that there is only skin and fascia, with a few of the innermost fibres of the crico-thyroid muscle, and perhaps this very small artery, which need to be cut in the operation. The wound of this artery has been said, however, to cause death in a very young child, already more than half suffocated, by bleeding into the trachea;

but any hemorrhage from this minute source can always be stopped by the pressure of a tube passed through the opening, or by a cold sponge. When the vessel is, as sometimes happens, irregularly large, its very superficial position will indicate its presence beforehand, or enable it to be readily secured by twisting or ligature.

In the text-books you are directed to make first a vertical cut an inch long from the pomum Adami downwards through the skin and fascia, and then to cut horizontally the crico-thyroid membrane close to the upper border of the cricoid cartilage. Now, under a sense of impending suffocation, patients usually throw the head backwards, and this movement stretches the skin of the neck and tends to close this vertical incision, and thus to interfère with free inspiration through the wound. But this frequent movement tends, on the contrary, to open a transverse cut in the tissues. I therefore prefer, with a sharp, small-bladed knife (double-edged, if at hand), to make a single transverse incision across the lower part of the hollow depression felt by the finger, just above the cricoid ring, through the skin and membrane at once, right into the windpipe, and to extend it sufficiently laterally to introduce a tube. Such a wound will remain open even without a tube; sometimes, indeed, the patient will breathe easier without one. If a tube be used, it should be broader in the transverse than in the vertical diameter, and shorter in the length between the shield and the curve than the one adapted for tracheotomy. Upon the latter point I shall have more to say subsequently.

Sometimes the incision is found, in a narrow female or infantile larynx, to be too limited to permit free respiration or manipulation. In such a case I should extend it by a median vertical incision downwards through the cricoid cartilage, or, if the case demanded it, upwards through the thyroid. Experience has found that such openings in these cartilages heal well, and without producing the contractions or mechanical disarrangement of the laryngeal apparatus which were formerly dreaded.

The circumstances under which laryngotomy is advisable are those which are found in the fauces, throat, larynx, and rima glottidis; with the addition of those in which foreign bodies in the trachea and bronchi are freely movable, hard, and smooth, and which would consequently pass out either through the wound or through the glottis after the trachea is provided artificially with an alternative channel of respiration. Most cases of impaction in the rima glottidis by foreign bodies, by tumours growing from the ventricles of the larynx, epiglottis, or vocal cords, or by inflammatory swelling, which is traumatic or non-spreading, would be included in this category; and it might embrace many cases also of syphilitic or phthisical ulceration of the larynx in which the disease does not extend below the true vocal cords.

Above all operations, that of *tracheotomy*, being one of haste and emergency, demands the most simplicity in the construction, use, and number of the instruments employed. Numerous contrivances for opening the trachea have been invented, some with more or less theoretical excellences; but all these may be stultified by not being at hand, not being properly used, or necessitating an embarassing change of instruments in the operator's hand at a critical moment of the operation.

I have been accustomed ordinarily to use, and to recommend the use of, three instruments only—namely, a single-edged pointed scalpel; a pair of slender and somewhat elongated forceps, provided with a single hook at the ends, which project very obliquely towards and fit each other in the manner of the teeth of a rodent animal; and, lastly, a tracheotomy tube of appropriate size, constructed with an outer pair of spring blades held firmly together by a shield, and an inner tube which slides between them, and which can be removed for the purpose of cleanliness.

I usually prefer to stand on the left side of the patient, so as to cut upwards from, and not down towards, the sources of danger in the lower part of the neck; but it is not in all cases possible to have this choice.

The two operations of tracheotomy are performed respectively above and below the isthmus of the thyroid body. The

former is by far the more readily performed, and involves the fewest dangers during and after the operation. The site of the primary incision is, in both, pretty nearly the same—namely, the same vertical incision in the median line of the neck, about two inches long, and extended a little higher or lower as the case may require. In a short neck, whether infantile or adult, the incision extends downwards nearly to the top of the sternum when the operation is performed below the thyroid. If the upper operation is at first intended, and afterwards it is seen that the lower one is preferable, the change can readily be effected by extending the incision downwards. After cutting through the skin and fasciæ, a small anastomosing tributary of the anterior jugular is often divided, but gives little trouble beyond slight pressure with the finger. Sometimes, however, this communicating branch is enlarged so as to assume the proportions and functions of the entire trunk, and passes into the vein on the opposite side of the neck, and may require ligature. The sterno-hyoid and thyroid muscles are now exposed, the latter meeting each other in the median line, which is indicated by a mere areolar interval. Through this, as nearly as possible, the knife should next pass, and the muscle be held aside with the hooked forceps. A fascia covering the isthmus of the thyroid and the communicating branches of the thyroid arteries and plexus of inferior thyroid veins is now exposed. The surgeon can at this stage open the trachea either above or below the thyroid gland. To accomplish the former is, as I have said, more easy, on account of its comparatively superficial position. The windpipe is here covered pretty nearly by the same kind of structures as it is below; but the effect of the direction and action of the sterno-mastoid muscles, as soon as the skin and fasciæ are divided in the median line of the supra-sternal fossa, is to raise the edges of the wound, and to increase its depth very much at the lower part of the neck. The inferior thyroid plexus of veins is also met with below the thyroid isthmus, and in most cases requiring tracheotomy these are gorged and distended to the utmost on account of the arrest of respiration, and, when cut, bleed very profusely. Again, to the sides of the larynx are attached the strong muscles, the actions of which balance each other and hold it laterally tolerably steady. But since no muscles are attached to the trachea at the lower part of the neck, nor any fascial or other structures which would steady it laterally, it is moved about and sometimes even contorted by the plunging spasmodic respiration and heaving chest, and may be very difficult to fix, especially in young children. The nearer you get to the larynx, therefore, the steadier laterally does the trachea become, and the easier to fix and penetrate. The tracheal cylinder also diminishes somewhat in width downwards. And with the depth of the wound, the amount of the bleeding, and the motion and smallness of the trachea increase the difficulties and dangers of tracheotomy.

If it is determined to open the trachea above the isthmus of the thyroid, the upper part of the fascia which invests the gland and connects it with the trachea must be seized with the forceps, and the point of the knife applied so as to cut or scratch through it horizontally. The handle end may then be placed under the isthmus and made to push it downwards, and at the same time to separate it to a sufficient distance from the trachea. The isthmus varies much in bulk, being larger in females, and, proportionately, in children, than in the adult male. It seldom covers the first ring of the trachea, being usually placed opposite the second and third. Usually it may easily be displaced downwards so as to permit division of the three upper rings. To accomplish this, seize the fascia covering the fibro-cartilage or upper cartilaginous spaces as low down as possible, and a little on one side of the median line, with the hooked forceps, the teeth of which, projecting well downwards, will bite easily into its substance. Then, guided by the interval between the double straight blades of the forceps, pass down the scalpel and puncture the windpipe vertically, afterwards extending the incision upwards as far as the cricoid cartilage. A rush of air mixed

with sputum and blood usually follows the puncture; and sometimes, in the confusion and nervousness caused by this coming in his face, the young operator loses his self-possession, and lets go the trachea before a most essential part of the operation is accomplished—namely, the introduction of the silver tube. Now, for a speedy and satisfactory conclusion of the operation, it is essential that the hold upon the trachea, being once obtained, should not be let go; but, the knife in the right hand being changed for the outer part or spring sheath of the tube, this should be firmly compressed between the finger and thumb and carried down along the forceps through the tracheal wound, and then pushed in a curvilinear manner home to the shield. The holes in the sides of the shield should be first furnished with narrow tapes, conveniently rolled up, to be tied round the neck, to hold in the instrument when the operation is completed. The inner tube should not usually be passed in until some of the spasm consequent upon the operation has passed away. The manipulation of the trachea must usually be done (after the first glimpse has been obtained) by the feel rather than by the sight. When the forceps has obtained a proper hold, it acts very efficiently in the double capacity of a holder and a guide to the knife as well as to the tracheatube. If sufficient room cannot be obtained by pushing down the thyroid isthmus, the incision may be extended upwards through the cricoid cartilage. Although it is perhaps better to avoid this if possible, yet its performance is not usually attended with any after-inconveniences.

When it is intended to open the trachea below the thyroid isthmus, it may be necessary to carry down the external incision a little further. The fascia inclosing the inferior thyroid veins in the middle line should be carefully cut or scratched through by the combined use of the knife and forceps; the communicating veins should be rather torn than cut, the tension necessary to tear them being beneficial in forcing back the blood contained in them, and rendering them less liable to bleed for a few minutes, until the tube has been introduced and the blood kept out of the trachea. In this case the inner tube should be put in immediately to stop out the blood as much as possible. In performing this lower operation increased dangers beset the operator from the close contiguity of the left innominate vein and the innominate artery. In very young children, also, the size and high position of the thymus gland may be a source of embarrassment. It may project out of the cavity of the thorax and overlap the left innominate vein, which, usually in these cases turgid with blood and provided with thin coats, may easily be injured either with knife or forceps in pushing downwards the protruding thymus. The innominate artery here lies to the right side of, and somewhat upon or in front of, the trachea, and in many adults even may be seen and felt to pulsate inside the sterno-mastoid in the suprasternal fossa. The difficulties in opening the trachea are increased under these circumstances by the much greater depth of the windpipe, by the bleeding from the inferior thyroid plexus of veins, and by the more mobile nature of the trachea at the point operated on. In young children these difficulties are increased by the small size and yielding nature of the walls of the windpipe itself, the wound in which can best be made, and, when made, held open for the introduction of the tube, by steady traction with the hooked forceps lifting forward one lip of the slit in the windpipe, so as to elevate it above the other. The closed valves of the outer tube can then usually be easily introduced by a slight sideling motion. A fault often committed by young operators consists in letting go the trachea through the movements of the patients or nervousness, or in changing instruments before the opening in the tube is made sufficiently large. Then the air rushing out of the incomplete wound, mixed with blood, froths and churns up out of the wound, and obscures all the landmarks of safety. An attempt is then made to enlarge the opening in the windpipe, with the effect probably of making a second and independent wound. The remedy for this is to get a firm hold of the trachea, and not to let go until the tube is fairly lodged. It is advisable in using the knife in this situation, and under

these circumstances especially, always to keep the back of the knife towards the sternum, so as to avoid touching the distended innominate vein or innominate artery. In persons past the middle age the difficulties assume a different shape. They usually arise from the ossification of the tube, or some morbid change in or near the thyroid gland. In case of the patient being beyond middle age, and of the male sex especially, in whom calcification of the trachea is more common, it is advisable to be provided beforehand with a pair of strong scissors, or cutting forceps bent edgewise at the joint, with short, stout blades, of which the under one is pointed; these are provided with long handles of convenient thickness. If the scalpel fails in making impression upon the trachea, this can be substituted, the sharp blade being thrust through and turned upwards in the tube. With this it will be easy to divide an ossified trachea, or even to remove a piece, if desirable. The lower operation may be required in cases of tumour of the thyroid isthmus, of foreign bodies impacted near the bronchi, and in removing the false membranes in croup.

Among the dangers of the lower operation of tracheotomy must be reckoned, in addition to those of the operation itself, such as bleeding from the inferior thyroid plexus of veins, wounding the inferior thyroid artery by a slip of the knife on one side of the trachea, or of the innominate vein or artery, those consequences which are secondary—viz., infiltration of air into the anterior mediastinum and general subpleural tissue, or of blood or pus into these structures, and the embarrassment of breathing and other bad symptoms which may ensue thereupon. One source of danger which has proved fatal in many instances, some of which have been recorded in the Transactions of the Pathological Society during the last few years, arises during the subsequent wearing of the tracheotomy tube under the constant friction of the chest-walls in breathing. A progressive ulceration, either downwards from the shaft, or forwards from the point of the tube rubbing against the anterior wall of the trachea, has at length opened into the innominate artery, and proved suddenly fatal by hemorrhage into the bronchi. Another danger is the separation of the shaft of the trachea-tube from the shield at the joint which unites them, permitting the shaft to slip entirely into the trachea. Two cases of this kind have occurred in the practice of Mr. Henry Lee, and of Mr. Holthouse, and were brought forward at the meeting of the Royal Medical and Chirurgical Society on Jan. 9th, 1872, necessitating another subsequent operation for the extraction of the tube. A valuable suggestion was made on this occasion by Mr. Brudenell Carter, that the shield and tube should be made in one piece of metal, without the intervention of solder, which corrodes sooner and more easily, or that the joint should be gilded over to guard it from the combined action of air and liquid secretion. It is not, however, this action alone which contributes to this unfortunate result, but also, and more powerfully I believe, a defect in the shape of the tube usually employed. For the lower operation of tracheotomy the shaft of the tube between the shield and the curved part is, for male adults especially, much too short. The consequence is, not only a difficulty in making the tube lie evenly and comfortably in the trachea and with the lower opening fairly in a line with the axis of the trachea, instead of being inclined, as it usually is, so as to look towards, and press with its sharp edge upon and rub against, the anterior wall just under the innominate artery—but there is also a considerable traction inwards exerted by the concavity of the curve lying in the trachea, against the shield resting obliquely upon the surface of the skin. It is this traction, combined with the suction power and constant motion exercised by the chest in respiration, which contributes most to separate the parts of the tube from each other, and to suck in the shaft of the instrument. For the upper operation of tracheotomy the tubes in common use do very well under ordinary circumstances; but for the lower operation in adults, where the trachea lies an inch and a half deep, and may lie deeper, as in cases of tumefaction from emphysema, inflammation, solid growths,

or spinal and chest deformity, it is essential that the length of the tube from the shield to the culm of the curve, should be *an inch and a half*, instead of barely half or three-quarters of an inch, as we find in the tubes at present in use.

I must here impress upon you the great importance of proper care and treatment subsequent to this operation. After clearing the tube from blood and thick, viscid mucus, the air which is inspired through the tube must have communicated to it the moist and warm characters which it normally acquires in its passage through the nose, mouth, fauces, and larynx. This can be done immediately by dipping a large coarse sponge, well cleansed, in water of a temperature a little above that of the body, and tying it loosely on each side to the tape which encircles the neck. As soon as possible, also, the air of the sick chamber should be made warm and moist by a steam kettle with a long tube placed on a good fire. In large rooms or hospital wards it is better to erect a sort of tent of blankets over the bed, close beside the fire, and put the mouth of the steam tube under it. A great many tracheotomy cases, both in children and adults, die afterwards from bronchitis and pneumonia, which, sometimes brought on, are always aggravated by the admission of dry cold air to the lungs. The above precautions are of course even more necessary in cold and frosty weather.

In conclusion, there is one point which it may happen to be important to keep in mind, and that is, the duty of completing and finishing these operations upon the windpipe, when once begun, in the face of every possible eventuality which may arise in the course of it, even up to and beyond the apparent death of the patient. In no case is the truth of the saying, "while there's life there's hope," more paramount than in operations to relieve suffocation, to which, as in cases of drowning, the higher truth may be almost applied, that "beyond life there's hope." One of the most striking instances of resuscitation after apparent death during tracheotomy I have been lately witness to. A few weeks ago I was called in the middle of the night to the relief of a medical man, considerably beyond middle age, suffering from laryngitis combined with bronchitis. On hastening to his house, which was a considerable distance from my own, I found Dr. Goddard, of Edgeware road, in attendance, who had judged very rightly that an operation afforded the only remaining chance of relief from the very threatening symptoms presented by the poor patient, and had accordingly requested my assistance. A glance at the distressed countenance and the dusky lips and finger-nails, a hurried pressure of the failing pulse, a brief listening to the raucous laryngeal noise and heaving chest, deprived of vital air, led me, after a hasty consultation, fully to coincide with the imminent necessity for tracheotomy, with a view of at least prolonging life. While the rapid incisions were being made to expose the trachea, the patient suddenly ceased to breathe altogether, the pulse stopped, the eyes rolled over and seemed to become glazed, and after a brief spasm of the facial muscles, usually observable just before dissolution, all seemed to be stilled in death. A considerable obstacle was now met with in extensive and very hard ossification of the trachea, upon which the scalpel made little impression. With the words upon my lips, "I fear we are just too late," but remembering the maxim I have endeavoured to impress upon you, I persevered notwithstanding, and by the exercise of considerable force, and by first converting the edge of the scalpel into and then using it in the fashion of a saw, I got through the hardened trachea and passed in the tube. After employing the usual methods of artificial respiration, we were in a few minutes encouraged by a gentle sigh of inspiration; and in less than a quarter of an hour the patient was sitting up in bed, breathing freely through the tube, expressing himself as comfortable, and writing upon a slate a professional criticism as to the urgent necessity of the operation and the dexterity of its performance.—*Lancet*, March 9, 1872.

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Abstract of a Lecture on Typhoid Fever. By Sir William Gull. Delivered at Guy's Hospital, June 20, 1872.

[We copy from the *Lancet* (June 29,

1872) the following "full abstract" of the above very interesting and instructive lecture. This lecture derives additional interest from the fact that its distinguished author was one of the medical attendants of the Prince of Wales during his recent severe attack of typhoid fever.]

The Lecturer began with the remark that it is about two hundred and fifty years since one of the kings of England died of ague; but now the improved condition of agriculture and drainage in this country is such that ague has become rare, and certainly very few die of it. He then expressed his belief that two hundred and fifty years hence few will die of typhoid fever, inasmuch as this disease is as preventable as ague. Typhoid fever is, *par excellence*, to be ranked amongst "diseases," because it is caused by a virus—a virus of nature—which may get into the healthy body, and increase in it, and destroy it. It is an accidental condition, and not one of the ordinary processes of nature. Therefore we ought to rise up in arms against it, as we Englishmen would rise up in arms against any enemy that should attack us or threaten us.

Sir William said that he was not going to give a lecture on typhoid fever, as such a thing would be impossible in the time allotted; but he appealed to those present, as Guy's students, to sympathize with him, as a Guy's man, in the late conditions which have given rise to the increased attention to the subject of typhoid fever. Many diseases that were formerly very fatal are recoiling before the advances of civilization—to wit, the plague, ague, and even cholera. Typhoid fever is stated to kill 17,000 a year in England; how great, then, must be the number attacked! It stood among the preventable diseases, and it was important, therefore, to know how it originates. There is no scientific theory, but there is a good working theory on the point. The origination of the disease is, somehow or another, connected with drainage. It has, therefore, been called the filth fever; hence to get rid of the filth is to get rid of the fever. It seems as if this really is so, for Millbank Prison was infested with typhoid and dysentery, but now the water-supply has been changed, and the drainage attended to, and these diseases have almost entirely disappeared. No one can approach a case of typhoid fever without paying some attention to hygiene. It is no use tinkering with the disease if one does not try to prevent it, and it no doubt may be prevented. The theory is that it is connected with germs which get into the blood; we know nothing about these germs—the air is full of them. There is an idea that they are imbibed by drinking water, and that they increase and multiply within the body. Although this has not been demonstrated, yet it is a good working theory.

The first thing then to be done is to find out what will prevent the disease. Some may say, "Tell us what will cure it;" but this is not of such importance as prevention. Sir William next said that he liked the name *typhoid* because the disease resembled *typhus*, and yet it was not typhus. It is an error to suppose that there are symptoms of typhoid fever essentially, as the poison may get into the body, and destroy life, without setting up any symptoms of typhoid fever proper. Some years ago a case was taken into Guy's Hospital, the patient having become suddenly ill; and shortly after admission he died, but the cause of death was not suspected till a post-mortem examination revealed perforated typhoid ulcers of the intestines. This patient had gone about his work regularly up to the day of his death. The next subject is the diagnosis of this disease. This is sometimes at first uncertain; the patients rarely come till they have been ailing some time. The furred tongue, headache, malaise, etc., belong to other diseases besides typhoid fever, therefore the term typhoid is a good one, because the symptoms somewhat resemble those of typhus. Many other names have been given to this disease, but the one most generally adopted is typhoid fever. It has been called pythogenic fever, from its supposed origin from filth; but it is not advisable to accept this name, as at some future time it might be necessary to change again.

The history of an attack of typhoid fever is somewhat obscure. The poison lurks in the body some time before the real

onset of fever; it may be as long as five or six weeks. The disease then begins insidiously and irregularly; the prodromata are uncertain. Where does this poison work? Is it in the intestinal tissue, or in the mucous membranes, or in the absorbent system? We do not know; we say that it is in the blood. Where are these lurking beginnings? These are probably in the intestinal system, for we find digestive disorders and disturbance of the bowels in the first instance. It is, however, very difficult to say when the disease begins; but if the ordinary course of health be represented by a straight line, we shall find at the commencement of the disease an abrupt deviation from this straight line, and which deviation goes on increasing till the fourth to the sixth day; consequently, we find that on the fourth day the patient is ill, and on the fifth or sixth day very ill and obliged to keep his bed. It is about this time that we first see these patients as a rule, and how are we to tell that they have got fever? Well, by the little instrument called the thermometer. Now, if on even the first day the temperature be normal in the afternoon, there is no fever. In typhoid the temperature increases 1.5° to 2.0°, or even 2.5° F. in the first twenty-four hours. If a person who has been exposed to typhoid fever have a headache, and his temperature be 101.5° on the first day, it may be typhoid; but if, as is sometimes the case in persons who have been nursing, the temperature be below normal, or even if it be normal, you may be certain that there is not fever present. On the other hand, if on the first day the temperature be 105°, you may be certain that the disease is not typhoid. We see, therefore, that whether the temperature be too low or too high the thermometer will greatly assist us in making a diagnosis. The temperature goes on rising about 1.5° per diem till about the fifth or sixth day, when it reaches its maximum of about 103.5° or 104.0°, or even more. This is not absolutely true, because some persons may go through typhoid fever and know nothing at all about it. In this disease, therefore, we see that there is at first a long and uncertain prodromal stage, and then the onset of fever, which is insidious. Although the degree of temperature is reliable in determining the presence or absence of fever, the same cannot be said of the condition of the pulse, for, in nervous patients, the rapidity of the pulse may be greatly increased, and yet no fever be present. It therefore becomes an important thing to use the thermometer in practice; it will save many errors if used at the proper hour of the day—that is, in the afternoon.

To return to the course of typhoid fever, we find (still adhering to the chart) that on the twenty-first day the curved line suddenly runs into the straight line of ordinary health, and the fever is completed. In some cases, however, this does not take place till the twenty-eighth day. During this course we cannot give an answer to the queries of the patient's friends, "Is he better?" We must refer them to the chart, and tell them what is the course through which the disease must go. "We shall find no word 'better' written anywhere on the curve." Without this is borne in mind much annoyance may be given to the friends, for in the morning the patient may be cooler and appear better, but in the evening he is hotter and appears worse, and if the medical man were to alter his opinion according to the degree of temperature the friends might say that the attendant knew nothing whatever about the disease. It is necessary to wait the natural term of the disease before we can say whether the patient is better; moreover, we must bear in mind that two charts of the course of the disease may be drawn out, one in which the disease is represented as lasting twenty-one days, and the other in which it lasts twenty-eight days. But it is not always easy to say which is the twenty-first or twenty-eighth day, as it is so difficult often to fix the date at which the disease began; but by carefully recording the temperature we may tell the time to a couple of days. On the other hand, it is not always that we can say positively the patient is better on these days, for the disease may, as it were, begin again, and exactly repeat itself, and this repetition may last twenty-eight days more, or it

may even triple itself, as Sir William taught many years ago, when lecturing on this subject to the students at Guy's Hospital. This triple attack may last as long as the previous ones. These repetitions have been found on post-mortem examination to correspond with fresh outbreaks of the intestinal affection; for in these cases, should death occur, some of the ulcers will be found almost healed while others are just beginning to be affected. It is always necessary, therefore, to give a prognosis which shall allow of the possibility of these secondary attacks. But these repeated attacks do not necessarily last as long as the previous ones; they may be much shorter, lasting only one, two, or three weeks. So that typhoid fever may have a simple course of twenty-one days, or a prolonged course of twenty-eight days, or a double or triple course, the duration of which equals that of the previous attack; or lastly, a complex course—one or two attacks of ordinary duration, with another of shorter duration.

Now, in whatever manner the poison of typhoid is introduced into the system there is a concentration in the ileum. The presence or absence of diarrhœa depends on the implication or not of the large intestine. Although the ileum is the focus of the operation of the poison, yet it does not end here, for it is reflected to every organ of the body. The incidence of the poison is on the ileum, but the reflection is over the whole body. The body reacts to these conditions, and the fever is a reaction to the local condition of the bowels; but this does not imply that typhoid fever is a local affection of the bowels as was formerly taught. This poison reacts in other ways, as by setting up ulceration in various parts of the body. He was once called to the case of a young girl who was sickening of an illness. She had a discharge from the vagina, which led the medical attendant to doubt the girl's chastity; but he (Sir William) said that it was typhoid, and that the discharge was due to ulceration of the vagina. Another case, in Guy's Hospital, was treated as a gonorrhœa; but in reality the patient had ulceration of the prepuce from typhoid fever. In a third case, the patient had perforating ulceration of the larynx, and he suddenly became emphysematous over the body, which "floored" him (Sir William); but this case was shown after death to be one of ulceration of the larynx occurring in the course of typhoid fever. This disease then is not a local one, although the focus of the action is in the ileum. But to return to the chart. About the ninth day of the disease mischief begins to show itself in the intestines, and at this time the deposit may open up a large bloodvessel, and thus give rise to severe hemorrhage, or, if it go still deeper, perforation of the bowel may take place; or the bronchial membranes may become affected, or the bronchial glands enlarged, which may give rise by reflex action to spasm of the larynx. Every organ in the body is affected if the disease be severe. Every part of the body may be affected through the nervous system. There is a tendency to reaction. There may be pleurisy; or the enlarged mesenteric glands may soften and suppurate, which may be followed by purulent infection; or the kidneys may become diseased. In fact, any organ may become affected through the action of the nervous, venous, or other systems.

Now as to the treatment. This disease cannot be cut short, even in its early stage. Some have thought that it could be done by emetics, but few think so now. Others have thought that a purge of calomel and colocynth would cut short the attack, but this has been almost entirely given up. Others say that large doses of quinia will shorten the attack, or, at least, prevent serious complications; but Sir William related a case to which he was called, where large doses of quinia had been given, but the man was almost dead from hemorrhage, so that, in this case, the disease was neither cut short nor complications prevented. At the present time it must be granted that when once the patient has begun to go down the curve we must not dose him with medicines—we must not give him physic. The best thing is to place him in bed in a horizontal position, and reserve his nervous power, remembering that he must, if he live, go through the whole course of the disease.

He has to go through the reactions of his nervous, absorbent, and nutritive systems; he has, in fact, to go through "a great physiological storm." Let the patient alone then in this stage; "an early rest will save his power." But how is he to be treated through the remainder of the course? Is there anything to make the course less severe? Probably not. Quinia has been tried for this also, but has failed here as signally as when given to cut short the disease. It must be said that all the treatment consists of simple measures and simple diet. Medicines are only required for special conditions: for instance, if diarrhœa occur, some would give what is called "chalk mixture;" but we must remember that this has to go through about twenty-five feet of intestine. The best thing is to fill the rectum with five or six ounces of starch; it is not even necessary to put any opium with the starch. The diarrhœa only takes place when the rectum, sigmoid flexure, or descending colon is affected or irritated by acrid matters; hence, if you fill these the contact of noxious matters is prevented, and the diarrhœa checked. Time would not allow of more being said on this. [Here Sir William said he was not lecturing on typhoid fever, but only giving a few thoughts.] If hemorrhage occur, many would give gallic acid, or tannic acid, or lead, or some powerful astringent. But do not so; "don't begin with all your great guns at once." It is best to trust to the hemorrhage to cure itself, which it will do, and keep the patient at rest in the horizontal posture, giving a little opium (half a grain) by rectum or mouth if necessary to quiet the intestines. Ice may also be applied to the abdomen. This is sound advice, although it may appear terrible. The objection to giving lead or gallic acid or other powerful astringents is that they are apt to make the patient sick, and in that manner perhaps to make the hemorrhage worse. Often delirium comes on in the course of the disease. The patient may get out of bed, or even commit suicide by jumping out of the window. What is to be done for the delirium? In the first place, never leave the patient alone day or night after he has begun to descend the curve, for delirium may come on at any time; therefore, he must be constantly watched. In the treatment of this complication remember that it is due to brain-irritation, and not to inflammation, as some have imagined. There is one great remedy for this, and it is alcohol; alcohol is the remedy for nervous irritation in typhoid fever, and, in fact, in any fever. How it acts is not certainly known, but it may be laid down that it is an important point in the treatment of all fevers. It allays nervous irritation and soothes the nervous system. Whenever, therefore, there is delirium or reflex irritation, give alcohol in some form or another, as brandy or wine; but when the result has been obtained, stop it; only give it when it is necessary. In fevers the use of stimulants is for the delirium, and it in no way alters the local processes, but only the reflex condition. All cases do not require alcohol, and some only require it occasionally, and for a short time Delirium even in the early stages may be checked by brandy, and never again come on during the whole course of the disease.

There is another point. Often the patient cannot or ought not to be moved out of the bed. How is he to pass his stools? There is a danger of bedsores if care be not exercised to prevent them; but no man who has a due care ought, under ordinary circumstances, to have a patient suffering from bedsores; sometimes, however, the circumstances are such that these sores cannot be prevented. The bed-pan may become the source of a bedsore which may carry off the patient. Avoid, therefore, every possible cause of irritation or abrasion of the skin. This is a point which is worthy of the consideration of every clinical physician. Again, it may be necessary to pass a catheter to draw off the patient's urine. Now this may be done in such a manner as to injure the urethra, which may be in a very tender state, and cause ulceration and severe symptoms, and even death. Use, then, a soft catheter, with all possible care and delicacy. In summing up he observed that the recovery from typhoid is dependent on attention to the smallest matters.

The time will come when this disease will become rare, or even die out.

We must save the patient's strength from the beginning, and not trust to medicines to cure the disease. The materia medica of fever is lessening every year.

Sir William would prefer to carry any one through typhoid fever by wines and soups and fresh air, rather than by the use of drugs.

HOSPITAL NOTES AND GLEANINGS.

Ununited Fracture of the Humerus successfully treated by Resection.—James W., aged 40, labourer, admitted into the Royal Infirmary, Edinburgh, March 7, 1871, under the care of Professor SPENCE, suffering from an ununited fracture of the humerus. The original injury was sustained twelve weeks before admission, from a fall upon the ice. The limb was set, but never united. Patient is a healthy-looking man, but of rather intemperate habits.

March 21. To-day Mr. Spence made an incision, three inches in length, over the seat of fracture, exposed the ends of the bone, and, without removing them from their bed of soft parts, cut off with the bone-pliers the rounded extremities of the bones. The arm was then put up in rectangular splints. It need only be remarked, further, that the wound healed well, without a single bad symptom supervening. The discharge was never copious, and the bone showed a great tendency to unite from the first.

On May 9, "wound almost healed; bone quite firm; patient gets up every day."

A few days subsequently he was sent to the Convalescent House, with the splint still applied, instruction being given him to make passive movement of fingers and wrist-joint. After being at the Convalescent House he returned to show himself. The bone was firmly united; the thickening considerable. He feels it quite strong, but the movements of the elbow are not yet free.

He was dismissed, but strictly enjoined to continue passive motion and the use of the warm douche, as he had been doing whilst in the hospital.

Remarks.—The foregoing case affords a favourable example of the good results of a method or modification of resection in cases of ununited fracture, which I first practised in a case of false joint of the humerus in 1854, which was published in the *Edinburgh Medical Journal* for that year. In regard to that case I remarked: —"In deciding on resection of the ends of the fractured bone, I determined to remove no more than the rounded and atrophied ends, and to do so with as little disturbance of the surrounding parts as possible. . . . Having often observed in cases which had come under my notice, in which resection had failed, that fully two inches, or even more, had been removed, it always seemed to me that not only the amount of bone thus removed, but also the great denudation required to effect its removal, might account for the failure, besides increasing the risk of severe constitutional disturbance." The principle of this method of resection is one in which I have great confidence; and considerable experience in performing it since 1854 has confirmed me in the opinion I then formed.—*Med. Times and Gaz.*, June 22, 1872.

Amputation of the Thigh for Disease of the Knee-Joint.—It is so rare for the thigh to be amputated for disease of the joint alone that we record the following case, which presented certain exceptional features, that, in the opinion of Mr. HENRY SMITH, precluded any other operation.

The patient was a young man aged twenty, who had suffered more or less from diseases of the knee for three years, and had been under various treatment in hospitals and elsewhere, sometimes improving and then retrograding. He was admitted into King's College Hospital in March, at which time there was considerable tumefaction of the knee and wasting of the thigh; there was severe pain on pressure over the patella and the external parts of the joint; frequent painful startings of the limb occurred at night; and the patient was much reduced in general health. Mr. Smith ordered local and general treatment, with the hope that anchylosis might occur; but, the symptoms continuing, it was resolved that excision of the knee should be performed.

A very careful examination of the patient, however, was instituted, and it was ascertained that the urine contained a large quantity of albumen. Under these circumstances the operation was deferred, with the hope that the quantity of albumen might diminish; but no material change occurred in that respect, and amputation was determined upon and performed, the ordinary flap operation being executed. On examining the joint, it was found to be in progress of entire disorganization, the cavity being filled with purulent matter, the cartilages ulcerated, and the synovial membrane degenerated.

Mr. Henry Smith, in his remarks, stated that his pupils would be surprised to see an amputation of the thigh performed for disease of the knee-joint alone in a young man, and, in fact, he had had a great struggle to bring his mind to perform this operation; but with the evidence they possessed of the presence of degeneration of the kidney, he considered it would be highly imprudent to perform excision of the knee-joint. For although he believed the shock of the two operations was about equal, there could be no doubt that in the long run there was a greater call upon the constitutional powers after excision. He had been educated in the principle that amputation of the thigh should not be adopted for disease of the knee-joint alone; but there were exceptions to this rule, and the case before them presented one of these exceptions. Much as he regretted having had to adopt the step, he was firmly convinced that he had done wisely in rejecting excision, whatever the result might be.—*Lancet*, June 1, 1872.

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Treatment of Ulcers.—Mr. Thomas Bryant has very extensively carried out the treatment of ulcers by skin-grafting, and believes that many cases are now rendered curable that were not so previously, that the cure of others is facilitated, and that interest is given to a class of cases which previously offered little clinical instruction. By the process of grafting, large surfaces speedily cicatrize, which, under former circumstances, would have required many months, and that, too, without the contractions and subsequent deformities which, under other conditions, were too well known to follow in such cases. The practice seems applicable wherever a large granulating surface exists, and the only essential point to observe is that the surface of the sore should be healthy; this clinical fact including another, that the patient's health is good, for there is no better barometer of health than a sore, its surface assuming a healthy or an unhealthy appearance with every alteration in the general condition of the body. Mr. Bryant has attempted, by way of experiment, to graft skin upon sores that were not quite healthy, and has sometimes succeeded. In an indolent sore, in which a small patch of healthy granulations sprang up, he has succeeded in securing by transplanting a new centre of "cutification," that proved of great value in aiding the healing process, but in a larger number he has failed in securing such an end. It may, therefore, he thinks, be accepted as a truth that a healthy granulating surface is an important requisite for success. Mr. Bryant uses a pair of scissors after those recommended by Dr. Macleod. They take away a portion of skin that will cut into three or four pieces, and the section includes only the upper layer of the true skin with rete mucosum. He generally takes the skin from the forepart of the arm or the inside of the thorax. The pieces of skin should be placed upon the granulations about half an inch or three-quarters of an inch from the margin of the sore, and about one inch apart, and gently pressed in. There is no necessity to wound the granulating surface. They should be covered with a piece of oiled gutta-percha skin, and the whole supported with cotton-wool; a bandage being subsequently applied, so as to press moderately upon the part, and keep the dressing in position. On the third day, not before, the dressings may be removed, the greatest care being needed; a fresh piece of oiled gutta-percha skin being subsequently applied. The appearances of the engrafted pieces on the removal of the first dressing vary considerably; at times they will seem palpably to have taken root and to be alive; at others

to have disappeared altogether; whilst in a third class the surface of the cuticle will be seen floating, as a thin film, upon the secretion of the sore, the basement membrane of the cuticle—the essential part—being left. Under all these circumstances, however, the surface of the sore is to be cleaned with the greatest care, a stream of tepid water, either squeezed from a sponge or injected from a syringe over the part, being the best means to employ. The surface is on no account to be wiped, for the grafted portions of skin are easily uprooted, whilst those that appear to have died or that have disappeared often reappear at a later period as "cutifying centres." As soon as the new centres are established in large sores, other pieces should be engrafted, at about the same distance from the new pieces as those originally inserted from the margin of the sore; and in this way the whole granulating surface may be speedily covered with new skin, and a rapid recovery take place. There seems no objection to mincing the portion of integument which is to be employed into minute fragments—that is, into pieces of the size of millet-seeds; the thumb-nail of the surgeon being the best table for the purpose. Recently the practice of applying "skin-dust," or the products obtained by scraping the skin, has found favour, and met with some success. In the few cases in which Mr. Bryant has tried it, the ulcers healed, but he has no evidence to show that any new cutifying centres were established by the proceeding. In the hands of Mr. Poland it has, however, been of value. Mr. Bryant doubts whether it is yet proved that the newly engrafted skin possesses the same power of resisting disintegrating changes as the old skin. Some observations which he has made have led him to suspect that it is somewhat prone to break down and ulcerate on the patient walking after the sore has completely healed, particularly when the subject is past middle age.—*Brit. Med. Journ.*, June 15, 1872.

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Incomplete Hemiplegia of the Right Side, with Partial Aphasia.—By J. Lochart Clarke. A lady who had come from the country to see her daughter, found in the course of a few days, that she was gradually losing the use of her right hand and arm. The first occasion on which she experienced this weakness was, that one day, after beginning to write, she found herself unable to continue. Very shortly afterwards, she found that she was losing power in the right leg, so that she had great difficulty in walking; she also felt a sensation of "pins and needles" in the right hand, but not in the foot; at the same time she complained of great loss of memory. She was frequently quite unable to recollect many of the words she wished to use; and sometimes she transposed her words, or used wrong ones. Her articulation was very indistinct; but she could protrude her tongue and move it in any direction. There was a dull "heavy" pain on the left parietal region of the head, with a sensation of "creeping or drawing up" of the scalp, and some deafness of the left ear. There was no cardiac murmur, or any other sign of heart-disease.

Her general health was much deranged. Her tongue was loaded; her breath offensive; her appetite was gone; and she complained of nausea and flatulence, with a sensation at the epigastrium "as if something wanted to be removed." Her skin was dirty-yellow; her bowels constipated; but her urine was clear and without albumen. She was ordered a mild aperient, a blister behind the left ear, and the following pills:—

℞.—Hydrarg. subchlor. gr. vj; ext. hyoscyam. ℈ijss. Ft. pil. xij. One to be taken night and morning.

At the end of a week I saw her again, and found her decidedly improved. After two or three days the pills produced brisk purgation. She was ordered to repeat the blister and continue the pills. At the end of another week the improvement was still more marked. Her memory was much better, her articulation more distinct, her right arm stronger, and she could walk without much difficulty; but she still complained of dull pain, and "drawing up" of the scalp on the left side of the head. The bowels had acted about twice daily, and the evacuations on passing caused a scalding sensation. The

blister was repeated, and the pills continued. At the end of the third week she was nearly well; all that she complained of was flatulency, and the creeping or drawing sensation in the scalp of the left side. Her skin had lost its previously dirty-yellow colour, and her appetite was keen. She was ordered to discontinue the pills, and to take some rhubarb, ammonia, and ether in peppermint water. A fortnight afterwards, she returned to the country quite well.—*Brit. Med. Journ.*, June 15, 1872.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Bromide of Potassium in Poisoning by Strychnia.—Dr. C. B. Bates, of Santa Barbara, reports (*Pacific Med. and Surg. Journal*, May, 1872) a case of a man aged 22 who took, with suicidal intent, about 10 grains of strychnia. "His stomach was empty at the time, having had nothing but a cup of tea for breakfast. Upon my arrival, about half an hour afterwards, I found him in a most violent tetanic convulsion, and at once forced him to swallow a dose of tartar emetic and ipecac; then I sent for a stomach pump, but before the return of the messenger the emetic had commenced to operate. Its action was kept up for some time by the administration of copious draughts of warm water and mustard and water until the stomach was thoroughly evacuated. During the whole of this time convulsions were recurring every few minutes, and as I was satisfied there could now be no more of the poison remaining in the stomach, I gave him one grain of sulphate of morphia with about forty of bromide of potassium. Soon the paroxysms decreased in violence, and the intervals of rest became longer. The bromide of potassium in doses of forty grains was repeated every hour until he had taken half an ounce when he was out of danger, and all that remained of the muscular spasm was an occasional jerking of the muscles of the lower jaw."

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Poisoning by Sulphate of Morphia.—The uncertainty of the action of medicines and correctness of the maxim of Hippocrates, "*Experientia falax, judicium difficile,*" are forcibly illustrated by two cases of poisoning by morphia, related by Dr. H. A. DuBois (*Western Lancet*, June, 1872).

In the first case one-third of a grain of sulphate of morphia, injected hypodermically in a patient, an adult, suffering from colic, reduced the respiration to five in two minutes, produced profound stupor and almost total cessation of the circulation, and seven hours elapsed before, under appropriate treatment, the patient was restored to consciousness.

In the second case, a man unused to take morphia had swallowed at two doses upwards of eighty grains of sulphate of morphia, according to his own statement, which Dr. Du Bois thinks reliable, with the effect of producing delirium, followed by stupor, from which the patient recovered under treatment by stimulants and warmth and the administration of two ounces of tincture of belladonna in doses of a drachm every hour.

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Excision of the Kidney.—Dr. George A. Peters, it is stated (*Medical Record*, July 15, 1872), removed from a male patient at St. Luke's Hospital the right kidney for abscess of that organ. The result is not given.

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The Medical Register of New York and its Vicinity for the year commencing June 1, 1872. *Published under the supervision of the New York Medico-Historical Society*, A. E. McPurdy, editor. Vol. x.—We take pleasure in calling attention to this volume of 422 pages, which is replete with interesting information, and seems to be as comprehensive and complete as a work of the kind can be. In addition to a list of the physicians of New York city, their residences and office hours, it furnishes an account of all the medical institutions of the State, with the names of their officers, the medical societies with a list of their officers and members, also of those of New Jersey and Connecticut; an obstetrical table, equivalents of English and French weights and measures, a table of distances, postal information, hack fares, obituaries of New York phy-

sicians who have died during the past year, lists of medical periodicals issued in New York, of medical booksellers, of nurses, of pharmaceutists, etc. etc.—indeed nothing seems to have been omitted which could be desired in a work of the kind, and it reflects great credit upon its industrious author and on the society under the supervision of which it has been compiled.

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Bequests.—The late Wm. S. Rogers, of Boston, has bequeathed $50,000 to found a professorship of chemistry in Brown University, to be known as the Newport-Rogers Professorship. The late E. S. Pratt, of Buffalo, has bequeathed $10,000 to the Buffalo Hospital, New York. Our contemporary, the *Boston Medical and Surgical Journal* (June 27th), states that a few days ago the treasurer of the Massachusetts General Hospital received the large sum of $446,000, the bequest of the late John Redman. "Mr. Redman died some twenty years since, leaving a will by which the hospital was made the residuary legatee of his estate upon the death of a son who had a life interest in it. The advance in both real and personal estate since that time has increased the value of the legacy from $50,000, which the trustees of the institution once expected to receive, to nearly half a million."

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Heat of the Present Summer and its Effect on Mortality.—The temperature during the last week in June and the two first weeks in July has been almost unprecedently high, and with the result of largely increasing the mortality in our large cities, the principal victims being the very young and those of great age. The total number of deaths in Philadelphia during the week ending July 6th was 746, the largest number ever recorded here in any one week. Of these deaths, 512 were of children under five years of age, and 476 of children under two years of age. Cholera infantum claimed 274 victims, sunstroke 22, old age 20. In New York during the same week the mortality was even larger, having been 1567, more than 100 per cent. greater than in Philadelphia, while the population of the former is only about 40 per cent. greater than that of the latter.

The mortality in Philadelphia during the week ending July 13th was 852, of which number 497 were infants under two years of age; 383 of them being under one year. Cholera infantum had 310 victims, sunstroke 68, old age 29. In New York during the same week the mortality was 1056.

The heat in Philadelphia during the week ending July 20th was considerably lessened, and the mortality for the week was 587, being a decrease of 265 from those of the previous week. The deaths from cholera infantum were 210, from old age 14, sunstroke 10. From smallpox the deaths are reduced to only 6.

In New York the mortality was during the same week 961.

The extreme heat of the summer is not confined to this country. In Paris the heat was great, but the mortality had not increased at latest reports (28th June).

In India the heat has been, it is stated (*Lancet*, July 6th), exceptionally great. At Allahabad, at latest accounts, it had reached 115° in the shade, while at Hyderabad it was 116°.

FOREIGN INTELLIGENCE.

Hyperpyrexia; Treatment by Withdrawal of Heat.—It is a fact which no theory can alter, that if the temperature of the body rise up to, or above 107°, death is imminent; partly from the effect of the excessive heat on the vitality of organs, and partly from the excessive tissue-change which must be going on to produce this heat. Excessive and very rapid rise of temperature is seen more frequently in acute rheumatism than in any other disease. Dr. Wilson Fox relates a case in which, when the temperature was 107° in the rectum, the patient was placed in a bath at 96°; the heat, however, continuing to rise to 110° in the rectum, iced water was used and ice placed down the spine. In half an hour the temperature was reduced to 103.6°, and in another half hour to 99.5°. During this time six ounces of brandy were given, and subse-

quently eighteen ounces a day for several days.

The statistics published in Germany, comprising more than a thousand cases of typhoid fever, treated in various hospitals, show that the mortality in that disease has been reduced by more than one-half by the cooling treatment. This consists in not allowing the temperature to rise above a certain standard. If it does, it is at once lowered by baths or other means. This method of treatment is therefore not directed against the disease itself, but simply against a symptom, upon which a series of other symptoms depend. The patient is not plunged in a cold bath, but in one ten degrees below the heat of his body. It is only in certain cases that the use of absolutely cold water or ice is required. As many as ten or twelve baths in the twenty-four hours are sometimes required in order to keep down the excessive fever heat.

There can be no doubt that some cases prove fatal simply from the excessive temperature of the body consuming the tissues so rapidly. No case can long go on favourably with a temperature of say 106°, and as it is proved by a considerable amount of experience, especially in Germany, that an excessive temperature may, without any danger, be lowered artificially, this plan of treatment is imperatively called for in cases where an excessive temperature exists. Withdrawal of heat must, however, be practised with judgment, and not too rapidly, as the temperature will then swing back to and even beyond its former place. The rule ought to be, that the withdrawal of heat should be the slowest possible for the due attainment of our end. The patient should be placed in a bath of 100°, and the temperature of this gradually lowered, so that no shock is given to the system. On the removal from the bath quinia in doses of from five to twenty grains, according to circumstances, as advocated by Binz, will arrest the rapid reproduction of heat. This mode of treatment requires the incessant use of the thermometer, and the personal supervision of the medical attendant. A very interesting and successful illustrative case is related: it was one of cerebral rheumatism, which had supervened upon an ordinary attack of rheumatic fever, without heart affection. The temperature was 105.8°. A bath not being at hand, ice was put in five wide-necked bottles and placed in bed, close to the body, and ice also applied to the head. The cold was thus applied partially, and the same effect produced as by a less degree of cold applied to the whole surface of the body. — *Braithwaite's Retrospect*, Jan.—June, 1872.

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Diseases of the Muscular Walls of the Heart. — The Lumleian Lectures at the College of Physicians this year have been delivered by Dr. Quain. They treat of the Diseases of the Muscular Walls of the Heart. They have included matter of more than usual interest, and have thrown new light upon a scarcely recognized and hitherto unexplained form of disease. The lecturer described hypertrophy of the heart as a condition depending on an increase of any one of the elements which enter into the composition of its walls, its muscular fibres, its connective tissue, or its fatty tissue. With the hypertrophy depending on muscular tissue we are already familiar; it is the result of an increased development of power to meet obstruction in the course of the circulation. The hypertrophy of the fatty tissue is the result of the mere increase of fatty elements in the blood, which lead, in this particular situation, to the development of fatty tissue. The connective-tissue hypertrophy has been almost altogether lost sight of, apparently because it closely resembles, in its general appearances, ordinary muscular hypertrophy. Yet this pathological condition—connective-tissue hypertrophy — is utterly different in its origin and in its effects. A heart thus affected, when examined microscopically, is found to present to view not only the usual and limited amount of intermuscular connective tissue, but a decided hyperplasia of this tissue in all its stages of development from the globular to the spindle-shaped cell, and from this again to the formed bundle of fibrillæ. At the same time, the muscular bundles are seen surrounded

and compressed by this connective tissue. This condition is evidently due to a chronic myocarditis. A point of singular interest in the history of this investigation is, that it affords an adequate and scientific explanation of the origin of the change in those enormous hearts which are sometimes met with—cases in which diseases of the valves, pericardium, or kidneys, are alike absent. Our readers may probably remember an interesting lecture on this subject by Dr. Hyde Salter in these pages (July 28, 1866), describing the case with his usual fidelity and picturesqueness, and adding that it was one in which "the mind is baffled in seeking an intelligible solution of so difficult a problem;" and quite recently our Vienna correspondent (Dec. 16, 1871) directed attention, in clear and striking language, to one of these pathological puzzles, as they were and still are considered in the great school over which Rokitansky presides. The key to the problem was found in the investigation just described; and a striking example was afforded by the *à propos* examination by the lecturer of a specimen of a heart weighing forty ounces, which has long been preserved in St. George's Hospital Museum, where it was deposited more than thirty years ago, and has since been regarded as a remarkable example of hypertrophy, of which the cause was not sufficiently explained. Its proprietor was the well-fed under-butler of a ducal family, who might possibly have belonged to the class of extremely well-fed, not to say over-fed people, whom Niemeyer has considered to be the chosen subjects of idiopathic hypertrophy of the heart. The histological elements of the hypertrophy were shown by the preparations, which Dr. Quain placed upon the table, to consist chiefly in hyperplasia of the connective tissue. These specimens of disease not hitherto thoroughly identified are not to be regarded as mere pathological curiosities. The development of muscular fibre, connective tissue, and fat, having each a different origin, have also each a different therapeusis. In the first, we are warned to control overaction, and, so far as may be, to remove the obstruction which begets it; in the second or newly recognized form, which is the result of local inflammatory action, remedies ticketed formerly as antiphlogistic would be indicated; whilst the third calls for nutrient agents, and those which modify the development of fat.

It is always satisfactory, although not always possible, for a lecturer to be able to crown his work by the introduction of a novelty; and, although we can neither hope nor desire to be always hearing of new diseases, it is a matter of great importance so to study the recognized forms of disease as to analyze their real characters, and to identify species hitherto confounded. This is probably the most promising course of pathological research; for from it results a discrimination of the true character and origin of the particular condition to be treated, and therefore also the proper course of treatment for preventing the progress, arresting the development, or neutralizing the consequences of disease. Dr. Quain may be congratulated on having now added to his former services in the same field of investigation by his classical essay on *Fatty Degeneration*, wherein he defined its place as a retrograde metamorphosis, thus aiding in what Sir William Jenner, in his address to our Association at Leeds, described as "among the really great advances of medicine." Fully to understand the nature of the changes, and to identify this form of cardiac hypertrophy in the place which it will now take in medical literature, more detailed descriptions, with drawings, will be necessary; and these will be furnished with the text of the lectures, which, as we announced at the commencement of the year, will appear in our pages.—*Brit. Med. Journ.*, March 23, 1872.

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On the Use of Carbonate of Lithia in Gout and Uric Acid Gravel.—Prof. Ditterich, of Munich, states (*Schmidt's Jahrbücher*, Oct. 1871) that carbonate of lithia must always be considered as the most powerful remedy in gout and the morbid conditions depending upon excess of uric acid, and the salt has fallen somewhat into disrepute of late only in consequence of being unsuitably administered. The doses of five to ten grains, recommended

by Aschenbrenner, generally produce very unpleasant symptoms, as dyspepsia, catarrh of the stomach and bowels, with vomiting, etc., which require the discontinuance of the remedy. These doses, according to Prof. Ditterich, are much too large to act beneficially, and the single dose should never exceed twelve centigrammes (a centigramme is the hundredth part of a gramme, which is about 15 grains) and in twenty-four hours not more than a gramme should be given altogether. The next question to be asked in the treatment of gout, is whether the case presents itself in the acute or chronic form, for in the former lithia is unsuitable, but in the latter the carbonate may be given in the proportion of half a gramme (about 7½ grains) in a hundred and fifty grammes of distilled water, one or two teaspoonfuls to be taken every two hours. Thus administered the lithia causes no inconvenience and generally affords relief in from eight to fifteen days, during which the painful parts are covered with socks or linen coverings. According to Prof. Ditterich, the gouty swellings which have become hardened are not affected by the lithia circulating in the blood, until the adjacent parts of the limb have been brought into a state of congestion by stimulating embrocations. —*Brit. and For. Med.-Chir. Rev.*, April, 1872.

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On the Use of Ergot of Rye in Dysentery. —M. Luton, of Rheims, states (*Gaz. Hebdomadaire*, Oct. 1871) that during an epidemic of dysentery which lately prevailed at Rheims he employed in the cure of the disease most of the remedies which are considered efficacious, and met with various degrees of success. The epidemic was not a very severe one, and most of the patients recovered; but, in the majority of the cases, it appeared to M. Luton that the therapeutical action was not very evident, nor the relief rapid; and moreover some of the patients, especially among the most aged, died. It was therefore desirable that some new method of treatment should be found, which might give more satisfactory results, and the opportunity of doing so was offered by the case of a female patient, who was suffering at the same time from uterine hemorrhage and dysentery. The ergot of rye was prescribed successfully for the former malady, and it was found that the latter was likewise benefited by the remedy; and, in fact, as soon as the first doses had been given, a condition of constipation was induced, which lasted for four or five days. This first experiment led to the use of the ergot in simple dysentery, and it was found that an improvement in the symptoms, and eventually a complete cure, followed the new plan of treatment. M. Luton gave the ergot in powder, in the dose of 3 grammes (about 45 grains) a day, divided into doses of 50 centigrammes (about 7½ grains); and two or three days generally sufficed for a cure in ordinary cases. The ergot appeared to attack not only the hemorrhagic element of dysentery, but the whole disease; and the mucous secretions, the griping, colic, and fever, were equally relieved at the very commencement of the treatment.—*Brit. and For. Med.-Chir. Rev.*, April, 1872.

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Injection of Ammonia into the Veins as a Remedy in Snake Poisoning.—Through the courtesy of E. C. Bayley, Esq., Secretary to the Government of India, Home Department, we have had an opportunity of perusing a correspondence which has passed between Professor G. B. Halford of Melbourne, and Dr. Fayrer, on the efficacy of injecting liquor ammoniæ into the veins as a remedy for snake poisoning. Dr. Fayrer asserts that his frequently repeated experiments on the dog prove that in really severe and effectual bites this plan of treatment does no good, and that injecting any other stimulant would be of equal avail in cases, where stimulation might be beneficial. Professor Halford appeals to his experience of human beings, who had been bitten by the tiger snake, recovering under this plan of treatment, and says that experience gained by experiments on dogs may not be true with regard to men. There can be no denying that men have recovered after having been bitten, and subsequently had ammonia injected into the veins, but so have men who have been bitten and had no ammonia

injected. The matter is one for discriminating and unbiassed experiment and observation. Doctors are not remarkable for concord regarding questions less difficult of satisfactory solution than this, and the only way of settling this issue is to take every opportunity of putting the vaunted remedy to trial, carefully study the case, and record it. Both Fayrer and Halford agree in thinking that ammonia is a good stimulant, and should be given in all cases of snake poisoning. The question is—is Halford's plan of injecting it into the veins more effective than exhibiting it by the mouth or subcutaneously injecting it? We trust that those of our readers, to whom an opportunity of putting the practice to trial offers, may do so and report the result. It is always difficult in any case to say what might have happened, had a certain thing been done or not done; but accurately recorded clinical experience is the only safe ground of conjecture, and the only sound basis of assertion in such matters. The quantity of liquor ammoniæ recommended for injections of this kind is 30 minims of the liquor ammoniæ, B. P. specific gravity .959.

The treatment is said to be equally effective in asthenia arising from other poisons or causes; we have read of its successful employment in a case of poisoning by chlorodyne.—*Indian Medical Gazette*, June 1, 1872.

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Action of Phosphorus on the Bones.—At the Surgical Congress, held at Berlin in April, Herr George Wegener detailed the results of his experiments on the action of phosphorus on the organism, so far as they are of surgical interest. He finds that the fumes of phosphorus always produce periostitis of the jaws and facial bones in animals when the periosteum has been injured; when this membrane has not been injured, this effect is only occasionally observed. Phosphorus vapour also acts as an irritant on the exposed periosteum of other bones, but less intensely than on the jaws. Phosphorus given internally in pills, or in the form of phosphorus acid, affects the bones generally; but the results vary according as the animal is growing or full-grown. In growing animals new bone is deposited in much thicker masses than in the normal state. For instance, at the end of the diaphyses of the joints and at the beginning of the epiphyses of the long bones, the cancellated tissue is replaced by perfectly compact bone; and those parts of the bone which are formed from the periosteum undergo thickening, to such an extent as even to obliterate the Haversian canals. In grown animals the cancelli and the Haversian canals are narrowed; and in the tubular bones the medullary canal is encroached on by an osseous layer, and has even been observed, in fowls, to become completely obliterated. When the bones have been artificially injured by fracture or resection, the effect of the internal administration of phosphorus is to produce a richer and thicker deposit of new bone, presenting, especially after fracture, the characters of ivory. This effect on osteoplasis is produced by the daily use of doses so small as not produce any toxic results, even though long continued. The practical question raised by Herr Wegener was, whether these results did not point out that phosphorus might be found useful in osteomalacia and in fractures, and also in caries and rickets.—*Brit. Med. Journ.*, June 15, 1872.

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Treatment of Hæmorrhoids. — Hæmorrhoids, connected with prolapsus, were successfully operated upon by the application of nitric acid some thirty years ago by Dr. Houston, of Dublin. The method found great favour at the time, but has been somewhat displaced by the ligature, and the section followed by the actual cautery. Billroth, of Vienna, has of late revived Houston's operation, and reports excellent results, especially in those cases where frequent and dangerous hemorrhage had occurred. — *Lancet*, June 1, 1872.

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Eucalyptus Globulus.—Prof. Gubler, in a memoir published in the *Journ. de Pharm. et de Chimie*, states that all parts of this tree are impregnated with an aromatic substance, most abundant in the young branches, flowers, and leaves. The

febrifuge properties of the eucalyptus have been established by numerous observations. Under the name of "fever tree," it constitutes, in Australia and the neighbouring countries, the popular remedy against the prevailing fevers. The observations of a number of European physicians agree in placing its febrifuge powers in the most favourable light. Success in its use seems to be the rule, almost without exception, and it is in cases most rebellious to quinia and the other febrifuges that the leaves of the eucalyptus are reported to have produced the most remarkable results.

It would seem that these trees exert a marked hygienic influence wherever they are found. It is cited as a notorious fact that intermittent fevers are entirely unknown in regions favoured by their growth, whereas, in localities similar in respect to climate, soil, etc., but destitute of eucalyptus, the population is decimated by paludal fevers. It is generally supposed that the marsh miasms are neutralized by the aromatic emanation from the trees, but Prof. Gubler regards it as probable that the sanative results are to be in part attributed to the purifying effects of the offal of the foliage and the continually desquamating bark upon the stagnant waters. Of such waters travellers drink with impunity, whereas it is imprudent to drink from similar marshes not bordered by these trees.

Eucalyptus is employed as a stimulant and disinfectant dressing to wounds, and as an astringent and hæmostatic. It is useful in leucorrhœa; its success in this condition is attributed by Prof. Gubler to its toxic effect upon the several infusoria which exist in the vaginal secretion.

The power of the active principle of the eucalyptus in preventing the development of cryptogams is remarkable. Solutions of the salts of morphia, strychnia, atropia, aconita, and eserina, for hypodermic injection, prepared with water distilled from eucalyptus leaves, retained their limpidity for several weeks, while other solutions prepared with pure water became turbid with confervoid flocculi in a few days.

M. Clocz has discovered in the leaves of eucalyptus a volatile oil which he has designated *eucalyptol*, the formula of which is $C_{24}H_{20}O_2$, boiling between 170° and 175° C., and more or less soluble in alcohol, ether, and the fixed and volatile oils.

Eucalyptol possesses a peculiar, fragrant, aromatic odour. Its taste is aromatic, pungent, bitter, and slightly acrid. In moderate doses it is well tolerated. Large doses produce a slight sensation of burning in the mouth, extending to the throat and gullet, and exciting the secretions of the mucous membrane of the mouth and salivary glands. They cause a sense of weight in the stomach and interfere with the digestive process. In some cases, when largely given, headache, general excitation, great restlessness and fever are produced. These symptoms are of short duration, rarely continuing beyond a few hours. Such effects are never witnessed in the anæmic; with these, eucalyptol produces sleep. When breathed in too great quantity in a confined space, the vapours of eucalyptol produce symptoms of intoxication, sometimes accompanied with headache. The powdered leaves are prescribed in doses of from one to four drachms. The medium dose of eucalyptol is 15 to 20 grains.

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Use of the Essence of Eucalyptus Globulus to disguise the Odor and Taste of Cod-liver Oil.—The researches of Prof. Gubler on the *Eucalyptus Globulus* and its essence —Eucalyptol—has suggested to M. M. H. Duquesnel a trial of the effect of the Eucalyptol in masking the disagreeable flavour and odour of cod-liver oil, and the result, he says, has been most satisfactory. He mixes one hundred parts of cod-liver oil with one part of the essence of eucalyptus. The oil thus aromatized, he states, has neither the taste nor odor of cod-liver oil; it is readily swallowed and leaves in the mouth or on the tongue only the flavour of the essence with which it is mixed; and the disagreeable eructations which follow the taking of the pure oil are completely modified. The aromatized oil may be kept for a long time if the bottle in which it is placed be main-

tained very closely stoppered.—*Rev. de Thérap.*, June 15, 1872, from *Bull. de Thérap.*

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Cause of Uterine Movements.—A short paper of considerable interest to gynæcologists, by Drs. Aser and Schlesinger, appeared in No. 52 of the *Centralblatt für die Medicinischen Wissenschaften* for 1871. From numerous experiments, chiefly made on pregnant rabbits, in which the uterus was generally at rest when they began their observation, they discovered that, whenever the blood which circulated either through the brain or through the uterus itself became extremely venous, tetanic contraction of the uterus took place. As is well known, the blood which is contained in the vessels of any part of the body may be rendered venous in several ways. May be done by stopping the respiration, so that fresh air is prevented from reaching the blood in the lungs; in which case the blood becomes venous throughout the whole body. Or the same effect may be produced by arresting the circulation in a part, by tying either the arteries going to it or the veins returning from it, when the blood stagnates in the vessels, and becomes completely venous; so that this part of the body is, as it were, suffocated, while the rest of the body is well supplied with arterial blood. A third way of producing this condition is by bleeding profusely, so that too little blood is left in the body to keep up the circulation. Accordingly, the authors found that, when respiration was stopped in curarised rabbits, violent contractions of the uterus occurred in from ten to thirty seconds afterwards. This was due to the venous blood irritating the brain; and the same effect could be produced by cutting off its supply of blood through ligature of the innominate and the left carotid and subclavian arteries. Bleeding the animal nearly to death acted still more rapidly, and produced tetanic contractions of the uterus in between five and fifteen seconds. The irritation of the brain, which produced uterine contractions, was conducted down the spinal cord to the uterus; and, when the cord was divided, irritation of the brain in any of the ways just mentioned produced no effect. Stagnation of the blood in the uterus, produced by compression of the aorta, caused uterine movements of the same tetanic character, but which did not begin till the compression had been kept up from seventy to one hundred seconds, and were occasionally rather weaker than those which originated in irritation of the brain. If spontaneous movements of the uterus were present, they soon ceased after compression of the aorta was begun; and, when arterial blood was again allowed to circulate through the organ by removing the compression, a strong contraction of the entire uterus, quickly followed by rest, took place.—*Brit. Med. Journ.*, June 22, 1872.

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Amyloid Degeneration.—It is well known that amyloid degeneration is very common after long-continued suppurations, especially of bones and joints. But Professor Cohnheim gives (*Virchow's Archiv*, vol. liv., pts. i. and ii.) three cases in which it was found, after a suppuration of joints of only some months' duration. The suppurations occurred in healthy men from wounds received in battle. The spleen was affected in all the three, and the kidney in one, so that the amyloid degeneration was in an early stage. The author has no doubt that the degeneration was the result of the suppuration, and the cases are remarkable on account of its occurring after such a short period. —*Glasgow Med. Journ.*, May, 1872.

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Death after taking Hydrate of Chloral. —F. Jolly (*Bayer Ærztl. Intell.-Blat*, 1872, Nos. 13 and 14) states that, in the course of two years, during which he has employed hydrate of chloral in the treatment of the insane, he had met with two cases of sudden death following its use. The dose was in each case below the average, and the chloral was chemically pure. The patients during life presented no contraindications to the use of the remedy. One had taken the chloral at night for four evenings in succession; on the fifth evening, after taking it, the respiration and circulation at once ceased. The necropsy showed anæmia of the brain, acute œdema of the lungs, hyperæmia of the abdominal

organs, a perfectly healthy heart and vessels, and dark fluid blood. In the other case, chloral had been given twelve days in succession, with the effect of producing sleep after a short stage of excitement. On the thirteenth day, the patient died, after some stertorous breathing, a quarter of an hour after the dose. There was here found moderate œdema of the lungs; the blood was fluid, but normally distributed; the heart was large and flabby, and its muscular structure was pale, but not friable.—*Brit. Med. Journ.*, June 22, 1872.

[It may reasonably be questioned whether the chloral hydrate had any influence in producing death in these cases.]

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Deaths from Chloroform.—On June 8, an inquest was held at King's College Hospital on the body of William Lyon, aged 36, who was an engine-driver, and had been under treatment at the hospital for an affection of the jaw-bone. It was considered necessary to perform an operation, and he was placed under the influence of chloroform, and two minutes after its administration he expired. A verdict that deceased died from paralysis of the heart, caused by chloroform, was returned.

The death of a patient while on the operating-table, under the influence of chloroform, occurred on the 27th of last month in the practice of the eminent Vienna surgeon Billroth. Disarticulation at the hip-joint was being performed, on account of osteomyelitis. The femoral artery had been tied, and Billroth was about to apply the galvano-caustic wire in order to divide the soft parts after the enucleation of the head of the bone, when the patient's breathing became stertorous, and he died. Tracheotomy was immediately performed; but it and all other attempts to restore life were fruitless.—*Brit. Med. Journ.*, June 15, 1872.

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Tests for Detecting Strychnia.—The *Popular Science Review* states that Dr. Filhol, in a recent paper on this subject, maintains that strychnia should, in cases of poisoning, be obtained in the solid state; the alkalinity of its solution should be ascertained, as well as its intensely bitter taste; its behaviour with chlorine, and its blue coloration under the influence of sulphuric acid and oxidizing substances, should also be seen; while, lastly, as a very delicate reaction, Dr. Filhol observes that, with chloride of gold, strychnia (in solution) yields immediately a crystalline precipitate, which, although slowly, is yet distinctly formed in solutions containing one-tenth of a milligramme of the alkaloid. This precipitate and that formed by chlorine are at once dissolved by concentrated sulphuric acid, and, chromic acid being added, the well-known blue coloration that strychnia yields with this last reagent is produced. The presence of alcohol in liquids to be tested for strychnia should be avoided.—*Lancet*, April 27, 1872.

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Vital Statistics of France and Prussia.—A considerable sensation has been caused this week in France by the communication of M. Decaisne to the Academy of Medicine of an important study on the depopulation of France, indicated by its present vital statistics. Comparing it with Prussia, he shows that there 100 marriages produce 460 children, while in France they give only 300. The percentage of births to population in Prussia is 3.98; in France, only 2.55. The annual excess of births over deaths in Prussia is 13,300 per million; in France, 2,400. As to the future, the French population would require one hundred and seventy years to double itself; that of Prussia, only forty-two; that of Great Britain, fifty-two; that of Russia, sixty years.—*Brit. Med. Journ.*, June 15, 1872.

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Cholera.—This disease is said to be spreading in Russia and in India. In the former it is gradually extending from the eastern to the central and western portions. At Moscow it is prevailing in a most malignant form, and a few cases have appeared at St. Petersburg. It behooves the authorities of our principal seaports to exercise the greatest vigilance to prevent, if possible, its introduction into this country.

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Thomas on Diseases of Women, as offered to the profession in this, its third edition, is the latest and best work in the English language (or we believe any other language) upon this subject. We have taken great interest in carefully perusing its pages, and find that he has given his opinions without apparent bias by what has been previously said either by himself or anybody else. If he wishes to condemn, he does so in a positive and manly way, and when he expresses opinions he carries conviction that he is correct. The comprehensive character of the work commends it to the profession, since nothing within its scope will be found wanting; it may truly be said to be complete in discussing every topic legitimately in this branch of practice. The older works upon diseases of women have proven almost obsolete, in the rapid process of this department of medicine. A few years makes it necessary to change much of the teaching or omit it altogether; revision of a work upon diseases of women has been a necessity. That it will be less necessary in the future, is quite improbable, since knowledge in this department is nearly all of it of comparatively recent date, and our present views and modes of procedure will be modified by experience and by the correcting influences of time. Meanwhile the work of Prof. Thomas may be relied upon as containing what is known of the diseases of women.—*Buffalo Med. and Surg. Journal,* June, 1872.

HENRY C. LEA, Philadelphia.

THE MEDICAL NEWS AND LIBRARY.

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GUERSANT ON SURGICAL DISEASES OF INFANTS, ETC., 8 PAGES.

CLINICS.

CLINICAL LECTURES.

Clinical Lectures on Strangulated Hernia. Delivered at St. Bartholomew's Hospital, by Sir JAMES PAGET, Bart., F.R.C.S., Consulting Surgeon to the Hospital.

LECTURE I.—I propose to give you some lectures on Strangulated Hernia, a subject of great interest in practice, and one which you should do your best to learn while here; for it is only in a large hospital that you can see many cases of hernia, and only by the study of many cases that you can prepare yourselves for the great variety with which you may have to deal.

While I was on active duty at the hospital, I operated (in the hospital and in private practice together) on about a hundred cases of strangulated hernia, and I kept full notes of nearly all these as well as of some in which my colleagues operated. It is from these notes, and from the memoranda of several clinical lectures, that I shall draw materials for my present scheme.

It may seem to you that a hundred cases of strangulated hernia should be sufficient for some statistical deductions; but they are not nearly enough. The varieties of hernia, their complications, and the different conditions of people in whom they occur, make so great a variety of cases, that it would need a tabulation of at least a thousand cases to obtain conclusions of real value. I shall, therefore, use my notes and recollections only to

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enable me to tell you what appear to be truths on some of the most important practical parts of the subject.

Our first subject may be the grounds for determining whether strangulated hernia, or one supposed to be so, is to be submitted to operation. Speaking generally, one may say, that, when in a case of hernia signs of strangulation are present, and reduction by the ordinary means cannot be accomplished, the operation for reduction should be at once performed. But then, what are the sufficient signs of strangulation? and what are the ordinary, or, better, the reasonable means for reduction without operation?

In all well-marked average cases, that is, in such as are neither slight nor very severe, neither (as some divide them) acute nor chronic, these following may be regarded as the signs of strangulation justifying operation. The hernia, usually reducible, or now first formed, cannot be reduced by reasonable means. If not recently formed, it is larger than usual, tense, firm, or even hard; without impulse, without resonance, painful, and tender on pressure, especially at its mouth and neck. The bowels do not act, though they may often be felt contracting, and may cause much colic and spasmodic pain, especially at the navel and the pit of the stomach. With this pain there is commonly some tenderness, with a feeling of tightness in the abdomen, especially about the navel and between it and the seat of the hernia. The patient is often sick, vomiting nearly all the food and drink that he swallows, and, besides, a quantity of gastric and biliary secretion, or of the contents of the small intestines more or less diluted. The pulse and respiration are usually quickened and rather feeble; the patient feels and looks restless, low, and miserable—or, as it is called, "anxious." He cannot sleep or eat; and the hands and feet are apt to become cold and shrunken and dusky.

Whenever all these things are observed, and when they remain after such reasonable attempts at reduction without operation as I will presently speak of, you may hold that the operation should be done without delay. Much more, if possible, should it be done if these things be all worse than I have described. When the integuments over the hernia are inflamed, thick, sodden, and ruddy, or emphysematous; when the whole abdomen is swollen, tense, and tender; when the vomit is just like the liquid feces of the ileum; the pulse very rapid, feeble, and small; the skin cold and dusky and clammy; when the patient is dim in sense and mind, or in an anguish of misery with retching and hiccough; where all or the greater part of these elements of what the old writers called a *miserere* are combined; then, without trying any other method of reduction, you must instantly operate, though you may have only the slenderest hope of doing good, and a serious fear of seeming to do harm.

Thus far, one may speak very positively. In the cases which I have sketched, there are sufficient signs of strangulation; and if the hernia cannot be safely reduced without operation, the operation must be done. But you will not see many cases without seeing some in which, although the hernia may be irreducible, yet the signs of strangulation are very slight, obscure, incomplete, or in some other way not sufficient to make it nearly certain that the operation is necessary. It is an easy rule for all these cases that, whenever you suspect that hernia is strangulated, you should operate. If you will follow this easy rule, you will do some very bad surgery; you will kill a few patients whose lives you ought to save; and you will make many ill for two or more weeks who might be well in as many days or hours. You must avoid the easy rule, and learn the hard one of discriminating the cases that require operation. You must learn to discriminate those on which the operation must be done at once, without any previous attempts at reduction, and those in which before operation one or more attempts at reduction should be made with chloroform or other helps. For the purpose of such discrimination, let it be your design, in each case of strangulated hernia, not to choose any measure for its reduction till you have fully weighed the signs of strangulation of which I have spoken. For convenience of thinking, you may divide them into

the local symptoms, including all the characters of the hernia itself, and the less or more remote or general symptoms, especially the inactive bowels, the state of the abdomen, the vomiting, the pulse and respiration, and the general condition. I will try to tell how each of these, in its several degrees, may be estimated.

1. First, of the local symptoms, the irreducibility of the hernia, its unusual size, its tension or hardness, and the others which I enumerated, a few rules may include all that I can tell of these. It will be convenient to speak of irreducibility last; for, though it may seem as if it should be the condition decisive for operation, it is really a fallacious sign of strangulation; and, in some instances, no trial should be made to test its existence. As for the other local symptoms, their presence, even in a marked degree, is not decisive of strangulation, and is not sufficient to prove the need of operating when the remoter signs are not present. For the local symptoms may be found when a hernia, or its sac, is acutely inflamed, though not strangulated. In this state, which may follow injury, or even arise spontaneously, a hernia may become quickly larger than ever, firm and very tense, without impulse, very painful and tender, hot and red, and not at all reducible by any fair means. The sac may suppurate, the integuments may slough; and yet there may be no strangulation and no need of an operation. I have, indeed, only once seen this sloughing of the integuments over a hernia; but the case is not likely to be without parallel, and was a glaring instance of the fallacy of the local signs of strangulation.

A very stout elderly lady had a large umbilical hernia, which became painful, tender, and irreducible; her bowels did not act, and she felt sick, but did not vomit. There appeared no urgent need for an operation, and she was one in whom an operation was not to be undertaken lightly. But, after three days' watching, during which the local, but not the remoter, signs had somewhat increased in severity, I found that a large portion of the thin integuments covering the hernia had rapidly sloughed. I operated at once, though with little hope of doing good; for I supposed that the contents of the sac must also have at least partially perished; but they were not even severely strangulated; the mouth of the sac was too small for their return, but they were not tightly girt, and the intestine was only moderately congested. The sloughing of the integuments seemed due to inflammation in a very feeble person, and an ill-nourished part; and with the same feebleness the patient died on the day after the operation.

You may find, then, and not rarely, that the local characters usually present in a strangulated hernia may be imitated in an inflamed hernia which is not strangulated. And, though very rarely, many of the remoter signs—the constipation and the vomiting, the quickened pulse and breathing, and the rest—may exist when a hernia is inflamed but not strangulated. How, then, can you discriminate? Generally thus: in the inflamed hernia, without strangulation, the local signs precede, and greatly predominate over, the remoter and general signs; while, in a hernia which is inflamed after becoming strangulated, the remoter and general signs will still predominate over the local, and the history will tell that they preceded.

These means of discrimination, however, will not always suffice. You will meet with cases in which you will be uncertain whether the hernia be only inflamed and irreducible, or strangulated and inflamed; but in these cases you must not be uncertain of your practice. If you cannot very easily reduce the hernia, you must operate. The risk of operating on a hernia which is inflamed and not easily reducible is very small, in comparison with the risk of leaving one which is inflamed and strangulated; and even if you find reasons for waiting, it must be with the most constant oversight, for an inflamed and irreducible hernia may at any time become strangulated, and will certainly do so if not relieved by rest and other appropriate treatment.

For a second rule: if the remote signs of strangulation be present, the local signs are urgent for speedy operation in the same degree in which they are marked, or

in even a greater degree; for severe strangulation is often associated with slight local symptoms.

But, to judge rightly from the local symptoms, each may need to be carefully weighed as evidence for the necessity of operating, or of adopting other methods of reduction.

In reference, then, to the chance of reducing a hernia without operation, it is a bad omen when one has quickly come down much larger than ever before. A great majority of patients give this as the beginning of their troubles. Sometimes they tell that, while making a great effort, they felt the descent come larger than ever; that they felt some pain or more than usual increase in the hernia, and could not reduce it in the customary way. More often the larger descent has happened without apparent cause. While the patient was sitting, or in bed, or quietly walking, the descent has occurred; but, perhaps, most frequently it has seemed connected with some diarrhœa, or colic, or spasmodic pain, or with some kind of turbulent movement of the intestines, for some hours, or a day or two, before the descent. In some cases, moreover, the unusual size of the hernia is attained at once; in others by gradual increase. In some it very quickly becomes painful; and these are rather less likely to be reduced than those in which pain follows more slowly.

I cannot give you any satisfactory explanation of these unusual descents of herniæ or of their becoming strangulated; but let them teach you not to be deceived by any notion, that some unusual or startling event is necessary as a cause for the strangulation of an old hernia. And I believe it may be held as a safe rule in practice, that the more a recently-descended hernia exceeds its usual size, the less is the probability of its being reduced without operation; and I think that the probability becomes the less, the more the size of the hernia continues slowly to increase; for not a few of those that have suddenly become very large, and then have not increased, may be reduced without operation, if the patient be put under chloroform soon after the descent.

Similarly, when general signs of strangulation exist, the harder and more tense a hernia is, the less is the chance of reduction without operation. The hardness may be due to any one of several conditions, but, to whatever it may be due, it is an untoward sign. It is especially so, if the hernia be a small one. In large herniæ, the hardness may chiefly be felt at and near the neck and mouth of the sac, especially in inguinal herniæ; and you must take care not to be deceived by a sac which is soft and flaccid everywhere except at its mouth; for there may be strangulated intestine in the mouth of the sac, though the rest contain only soft omentum or fluid not sufficient to distend it. Nay, you must not let even a wholly soft condition of the hernia, or an open external ring, weigh down against the well-marked general signs of strangulation; for the piece of intestine at the mouth of the sac may be too small to give a sensation of hardness, or the whole hernia may be omental.

Again, if the general signs of strangulation exist, the more painful and tender a hernia is, the less, speaking generally, is the chance of reduction without operation. But here it is to be observed, that this rule holds less for recent than for old herniæ. A recent hernia may be horribly painful, apparently because of the tension of the stretched fibrous tissues about the sac's mouth. Yet such an one may commonly be reduced with the help of chloroform; but an equally painful old hernia, or one that has slowly become thus painful, may require speedy operation. And the operation must be all the more certainly done when, together with any of the remoter signs, there are other local signs, such as inflammation of the coverings of the sac, suppuration, emphysema, or the like. These are imperative for operation, without any previous attempt at reduction.

And for another rule: if the remote signs of strangulation be well marked, and the hernia cannot be otherwise reduced, you must operate, though there be no marked local sign at all. Or, even beyond this, if the general signs of a strangulated hernia be present—the constipation, vom-

iting, and others—and there be anywhere a swelling which may be a hernia, though it seem not likely to be a strangulated hernia, the operation must be performed at the seat of that swelling.

Reasons enough for this rule may be found in the many cases in which the local signs of a strangulated hernia are so little marked that the patient, having his attention spent on the misery of his vomiting and epigastric pain, and other symptoms remote from the hernia, says nothing of the hernia itself. In not a few of my recorded cases, the hernia had been overlooked for a day or more; and the patient had been treated for spasms, colic, dyspepsia, or some other imitated disease, while the hernia was obscurely becoming hopelessly strangulated.

This last rule of operating, though there be no local signs of strangulation, may lead you into trouble; into the trouble and discredit of performing an useless operation, and seeming to do much more harm than good. But this you must face; it is just in instances such as this that surgery must incur the risk of seeming to do harm rather than miss the opportunity of doing good. I have operated thus uselessly in three cases. One was an irreducible umbilical hernia, in which there was no strangulation; but vomiting and other signs of strangulation, caused by (I believe) gallstones. Another was a simple femoral hernia, with an internal strangulation of a piece of intestine far away from it. The third was an inguinal hernia with the same complication. All the patients died, and my operations seemed worse than useless failures. But you must face this risk of seeming wrong.

You may have to go further than in these cases; and, if, for instance, a patient have two herniæ that are irreducible, and signs of strangulation, and you cannot tell which is strangulated, you must operate on both. I saw Mr. Stanley do this; and no one could blame him, though, when death followed, it was found due to an internal strangulation distinct from both the herniæ.

These are the chief rules, so far as I have been able to learn, according to which you may use the local symptoms of a supposed strangulated hernia as a part of the evidence for determining for or against an operation for reduction. And to these it may be briefly added that the local symptoms are generally less severe in the old than in the young; in old hernia than in new; in omental hernia than in intestinal.

2. Let me now go on to speak of the guidance to be derived from the remoter symptoms; and, first, from the inaction of the bowels. This inaction, or rather this hindrance to expulsion, is a nearly constant sign in strangulated hernia, but it occurs in so many other cases that its sole presence is of little weight among motives for operating. Its absence is, rather, that which needs study.

One or more actions of the bowels, after other signs of strangulation have set in, are of no weight at all against the propriety of operating. They commonly occur, because usually after strangulation the part of the bowel below the constricted part empties itself. These actions of the bowels are not to be counted on either side of the question about reducibility or operation; and even a regular and frequent action is not an absolute prohibition, for the strangulation may involve only omentum, or only a part of the circumference of a portion of intestine. In these conditions, feces may pass along the canal and be discharged.

I had to see a lady for what was considered an abscess in the groin. The swelling was just over the femoral ring, and contained fluid and air. I punctured it, and let out pus and air and liquid feces, and presently I found a piece of hernial sac sloughed off and lying in the abscess. This, and the history of the case, proved that the hernia had, about a week previously, descended when the patient felt a sudden pain while driving. The hernia was so small that it was overlooked; its pain and the griping which it caused were thought due to colic, and were so treated. The bowels acted sufficiently, and gradually the little hernial sac and its inclosed piece of the intestinal wall died and sloughed off. Then came the signs of abscess over the femoral ring, and its outlet; and this was followed by complete healing and many years of health.

However, such cases as these are very

rare; and you may hold by the general rule, that you should not operate when the bowels act frequently or regularly, unless all the other signs of strangulation, both local and remote, be well marked.

3. The state of the abdomen is as little or less decisive in cases in which you may be in doubt. Of course, if it be sensitive and tender on pressure, either everywhere or in parts near the hernia, still more if it be distended and the muscles hard, this is an addition to the reasons for operating, and, I may add, to the reasons for fearing that you may be too late. It is more to be remembered that, when the abdomen is not tense or tender, when it may even feel nearly natural, yet you must operate if other signs of strangulation be present, and the hernia cannot be put back. For the changes of the abdomen are not common near the beginning of strangulation, and to wait for them would often be to wait till too late.

4. If I were asked which of the signs of strangulation I would most rely on as commanding the operation, I should certainly say the vomiting. Time after time, when the other signs were feebly, if at all, marked, the vomiting has been a sufficient guide to a timely operation. Many times, when all else was so quiet that it seemed rash to operate, the vomiting proved that it would have been much more rash to wait; and not one instance can I find in my notes in which neglect of the import of vomiting was not proved to be unwise. You had better hold the rule complete, that, when a patient has a hernia, recently become irreducible, and, with this, vomiting which cannot be clearly assigned to something independent of the hernia, you should operate. I am obliged to say recently become irreducible, because a patient with an old irreducible hernia may vomit, as any one else may, without any reason for suspecting strangulation; though in even these old cases you must be very watchful lest the vomiting may be an early stage of strangulation. But the rule is safe that recent irreducibility and vomiting are enough to justify the operation, even though there be no other sign of strangulation present. Much more must the operation be deemed necessary when with these the other signs of strangulation, in even slight degrees, coincide.

And in this judging of the vomiting, do not be too scrupulous as to its manner or its products. There are indeed some notable modes of vomiting when intestine is strangulated. The patient vomits all he drinks, and that soon after taking it; and besides, he vomits fluids of his own secreting; and this vomiting is commonly (at least in the later stages), with gushes of large quantities of fluid, without much retching or violence, as if the stomach slowly became full of its own secretions and those of the upper part of the intestine, and then, without any preceding nausea, suddenly emptied itself.

When you see these kinds of vomiting with a hernia lately become irreducible, or even with any swelling that may be a hernia, you may be sure that you must operate. But do not wait for any supposed characteristic mode of vomiting; do not be misguided by the absence of some peculiar fluid; nay, do not be misguided by the absence of all vomiting; for I have known it absent in the case of a very large hernia, which was certainly strangulated, and on which I operated successfully; and do not be misguided by an apparent diminution in the severity or in the frequency of vomiting, or by the vomiting having begun as soon as the hernia descended; for this it often does. Any kind of vomiting, if it be repeated, is enough to justify operation in a hernia recently become irreducible. Let me tell an illustrative case, which taught me the more, because it occurred in one whose life was of great value. He was aged 56, weakly, but laborious in literature. For three days after the descent of a hernia, which could not be reduced as it usually had been, there was not a single sign of strangulation, except this irreducibility, constipation, and occasional vomiting. He had no pain in or near the hernia; no feeling or aspect of illness; no hardness or tension of the sac; and the vomiting was only occasional, and there were often many hours of interval. But, after the three days, abdominal pain suddenly set in, with coldness and faintness, and

wretchedness. Within two hours I operated; but it was too late; peritonitis had already begun, and the operation was useless or worse than useless. He died in twenty hours.

Cases like this are frequent. All seems pretty well; and then comes an inrush of indomitable symptoms. The hernia is not acutely inflamed; the patient is not greatly distressed; he flatters himself that he is better, and the similar flattery of his friends is yet stronger; all are averse from operation, and you can hardly persuade yourself to be resolute about it. But there should be no hesitation. I lost the chance of saving this man's life, by underestimating the importance of occasional vomiting as a signal for operation. If you lose such chances, you will be still more blameworthy; for you will have had more warning than ever I had.

And once more; do not be deceived by the cessation of vomiting in the extreme condition of strangulated hernia. This sometimes happens; but it is a token of evil rather than of good, if general improvement do not coincide with the cessation of vomiting. So, again, sickness may be stopped by narcotism; but here again there is no evidence of such general improvement as might justify waiting.

5. In the recent stages of strangulation, if it be not very acute, the respiration and pulse are little affected. The pulse is usually accelerated, and at first may be full and firm. I find that it was between 80 and 90 in a large majority of the ordinary cases which I have recorded; and the respirations are, generally, I think, in due proportion to the pulse. As the other signs of strangulation become more marked, these, I think, always coincide with them. The pulse usually becomes quicker, feebler, smaller, unless indeed after the warm bath, when its strength and size may be greatly increased; the respiration, I think, keeps pace with the pulse.

Thus, these signs corroborate the others in urging to an operation. I have not any notes or knowledge of cases in which the pulse or respiration was so inconsistent with other signs of strangulation as either to justify or to forbid the operation. But you may have this for a safe rule; that if, while you are watching a case, doubtful whether there be strangulation, the pulse and breathing should increase in frequency, you may believe that there is a commensurate increase in the reasons for operating.

Lastly, as to the patient's aspect and general condition, little that is definite can be said. You read of an anxious expression, and it is called characteristic, as many other fallacious things are. I should rather call it an expression of distress or of misery; but, however you may name it, be careful not to think that you must see it before judging that it is right to operate for a strangulated hernia. The worse a patient looks or feels; the more he looks shrunken, worn, and old aged; the more miserable his sensations; the more is it unlikely that his strangulated hernia will be reduced without operation. But the reverse is not true. I have operated with full right, as proved by the result, on patients who neither looked nor felt miserable or anxious in any sense of the word. And I have seen a patient looking well and tranquil, in whom a femoral hernia, after seven days' strangulation, contained completely gangrenous intestine.—*British Medical Journal*, April 6 and 13, 1872.

HOSPITAL NOTES AND GLEANINGS.

Dr. Murchison's Clinic at St. Thomas's Hospital.—The interest and value to the ordinary student of cases in a medical ward are mainly dependent upon the teacher, and upon the time and trouble devoted by him to their study and exposition. How frequently one is met with the answer that there is "nothing much in the ward;" that "there are no interesting cases in at present," and such like expressions. There are perhaps occasionally seasons of dearth; but our own experience has led us to observe that "good cases," by, we presume, some unaccountable law not fully recognized, never fail to come in large and unfailing numbers under the notice and into the wards of the few clinical teachers of the London metropolitan schools. Every case of dis-

ease is interesting and instructive, provided the physician or surgeon take the trouble, and possess the knowledge and genius to make it so. We have never failed to find a practical application of these remarks in attending the visit of Dr. Murchison. Indeed, so far as clinical material is concerned, there is at present almost an *embarras de richesses* in his wards.

Embolic Hemiplegia, with Choreic Movements.—In some cases of chorea, embolism of certain cerebral vessels has been observed after death. The interest of the present case was accordingly enhanced, as the appearance of chorea bears on the pathology of the affection. The patient was a boy, aged 8, who had passed through an attack of acute rheumatism, with mitral valvular disease, and who, six months afterwards, became the subject of incomplete and apparently embolic hemiplegia of the left side, for which he had been admitted one month previously. It was observed at the time of admission into the hospital, that choreic twitchings, especially on the paralyzed side, were present. These, however, had now left, and the boy had almost entirely regained the use of the left side.

Well-marked and prolonged general Symptoms of Phthisis before the Appearance of Cough and Local Signs.—The patient, a man 39 years of age, had been for three months the subject of night-sweats, rigors, emaciation, and symptoms of hectic fever, and other signs of phthisis, without any of the physical signs of the chest denoting the existence of the disease, and without any cough. These, however, at length developed themselves in a well-marked manner while under observation. Such cases, Dr. Murchison observed, are occasionally met with.

Dropsy (chiefly Hepatic) relieved by the external and internal application of Digitalis.—The value of digitalis as an external application has been long recognized, although acted upon in a very limited degree. In the present case, the patient, a boy, aged 11, had been an invalid for twelve months. His illness commenced with an attack of acute rheumatism, which left him with a double mitral murmur. He was admitted into the hospital in November, when his legs were found to be œdematous, and his urine albuminous. The œdema diminished under acupuncture and other treatment, and the albumen, after a recurrence, entirely left; at the same time, evidences of ascites supervened, which Dr. Murchison believed to result from a fibroid condition of the liver, which had also in the mean time increased in size, consequent on the long continued cardiac congestion. Paracentesis abdominis was had recourse to for temporary relief after the abdomen had been greatly distended. The fluid again began to accumulate. The patient was treated by tincture of digitalis and iron internally, but without any effect upon the ascites. Digitalis was, however, in addition applied externally, in the form of infusion made four times the pharmacopœial strength, to the loins and abdomen, and with marked effect, the flow of urine increasing, and the ascites diminishing considerably.

Empyema; Rupture into Bronchus; Convalescence.—The subject of the affection was a man, aged about 40, the history of whose illness was an urgent attack of pleuritis in the right side, which was followed for eight weeks by the pain of distension, and subsequently the sudden expectoration of an enormous quantity of pus. He was admitted into the hospital four months after this occurrence, when it was found that the measurement of the affected side was less by an inch and a half than the healthy one, and that some symptoms of fluid still remained in the right pleural cavity. Dr. Murchison pointed out that, in this case, the general indication in the treatment had been to improve the general health of the patient. This had been followed out, and now, after a residence in the hospital of about six weeks, there were evidences of increasing recovery of the lung, and the patient had gained in weight.

Violent Diarrhœa and Vomiting from eating Pork.—In this case, the symptoms, which were rather violent, were clearly traceable to the patient's dining on pork. Dr. Murchison pointed out that cases were not unusual, in which an article of

diet which proved harmless over and over again, would produce in the same person severe gastric symptoms. Such was the case in the present patient.

Obscure Attack of General Dropsy, with Œdema of the Lungs.—The patient, a wretched-looking and dwarfed boy, aged 11, was suddenly seized, ten days before admission, with general dropsy, ascites, œdema of both lungs, and cough. No cardiac or renal mischief was discovered; and, although the liver was slightly enlarged, still there was not sufficient mischief in that organ to account for the dropsy. The spleen was large, but there was no increase of temperature. Dr. Murchison, in the absence of any apparent organic disease, was inclined to believe that the condition of the patient was due to some morbid condition of the blood. He was improving on iron.

Syphilitic and Amyloid Disease of the Liver.—The subject of the disease was a man, rather intemperate, aged 45, who, when admitted, presented symptoms of ascites, enlargement of liver, extensive cicatrices of the tongue, and cicatrices of previous ulcers on the legs; the spleen was also much enlarged, but the urine contained no albumen. The ascites diminished under treatment, and the liver was then found to be enlarged. He was now being treated by nitromuriatic acid and gentian.

Good Effects of Aconite in acute Pneumonia.—Amongst other cases of interest which came under our observation in the male wards, was that of a boy aged 15, who was admitted with acute pleuropneumonia of the right side and herpes labialis, and considerable increase of temperature. On the administration of eight-minim doses of tincture of aconite, with liquor ammoniæ acetatis every four hours, the temperature at once came down, and the disease did not increase.

A case of spinal meningitis recovering under treatment by belladonna and iodide of potassium; one of granular kidney in a painter, with hypertrophy of the left ventricle and chronic changes in the retina; and a case of double pneumonia, with extension of the inflammatory process to the pericardium, also presented some points of clinical interest.—*Brit. Med. Journ.*, July 13, 1872.

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Obstinate Constipation, probably dependent on Chronic Lead-poisoning.—The patient, a woman aged 40, was admitted with colic and constipation of ten days' standing. She complained of great pain in the abdomen, which was mostly paroxysmal, but from which she was never entirely free. There was very little tenderness of the abdomen, and no fever, but there were occasional sickness and vomiting. There was a distinct blue line on the margin of the gums, and this symptom assisted in arriving at the diagnosis of simple constipation, although it was impossible to trace the manner in which the lead had been introduced into the system. Small enemata of oil of laudanum, followed by large injections of gruel, were administered, with good results. One or two spontaneous motions were afterwards passed, and she seemed to be doing well. Latterly, however, she appeared to be again getting into the same state, and for five days her bowels had not been opened. She was now ordered enemata of assafœtida. To relieve the abdominal pain, she was at first ordered pills of belladonna and opium, with satisfactory results.

Intermittent Sarcinous Vomiting with Organic Disease of the Stomach.—The subject of this affection was a woman aged 49, who had been suffering for six months from vomiting of sarcinæ, and other symptoms pointing to malignant disease of the stomach. The vomiting came on at intervals of about seven days, and was very copious. All the gastric symptoms, including the vomiting, were relieved by creasote and morphia, in the proportion of one minim of the former to doses of the latter increased to half a grain.

Circumscribed Empyema pressing down the Liver: Paracentesis.—The patient, a female, about eight years of age, had fallen six weeks before admission. This was followed by pain in her right side. When admitted, she presented all the signs of pleuritic effusion in the lower part of the side. The lower margin of the liver descended below the umbilicus, and there

was displacement of the heart towards the left. The measurement of the right side increased greatly, without the dulness extending higher. At last fluctuation was detected at the most prominent part *below* the ribs. This was tapped below the ribs four weeks ago, and fifty-four ounces of pus were drawn off, greatly to the relief of the patient. The liver now ascended, but the level of the upper margin of dulness remained unchanged. The fluid, however, began to reaccumulate, and her temperature once more arose, and she presented symptoms of constitutional disturbance. A counter opening was now made in the back, when eight or ten ounces of fetid pus passed out. A drainage-tube was introduced and the pleural cavity was washed out daily with an aqueous solution of carbolic acid, in the proportion of one per cent. of the acid. Her progress had since been satisfactory; her general health and the local conditions had improved; and the temperature was now normal.—*Brit. Med. Journ.*, July 20, 1872.

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Cases in Dr. Peacock's Wards in St. Thomas's Hospital, and Clinical Remarks. —*Pleurisy.*—When we visited Dr. Peacock's wards lately, there had been a "run" of cases of pneumonia and pleurisy, acute and chronic, simple and tubercular—forming together a very interesting group. One woman had been admitted with one side of the chest so full of fluid that the advisability of paracentesis was mooted; however, a diuretic and tonic plan of treatment with counter-irritation to the chest had effected the absorption of the fluid, and the patient was convalescent. Dr. Peacock observed that pleurisy was generally described in books as a disease attended with active inflammatory symptoms; but in many cases the patient was scarcely aware of anything being wrong till one side of the chest was more or less full of fluid; there was generally some discomfort, but often little pain and little fever, little more indeed than great prostration of strength and some shortness of breath. The disease progressed insidiously until the patient began to suffer from dyspnœa, etc., due to the effusion. Pains in the chest were common enough, but were often due to other causes, as pleurodynia; still they must never be neglected. Simple pleurodynia occasionally passed into pleurisy. He had been annoyed more than once by hearing unmistakable friction after listening vainly on several days, and after having given an opinion that the pain was merely rheumatic. The study of text-books, again, would lead to the idea that there was but one sort of pleural friction; that usually described is the "sound of ascent and decent" of Laennec—a harsh, sonorous friction-sound, due probably to the rubbing together of the dry surfaces of the pleura. This is very characteristic, but is by no means the only, nor even the most common, form of friction sound; and, when it occurs, it has often disappeared before the patient is removed into hospital. Perhaps the most common form is what might be called "subcrepitant friction," a somewhat fine crackling sound, which differs from the subcrepitant *râle* chiefly in being very superficial. This form of friction is very commonly heard during the process of absorption of a pleuritic effusion; it is probably due to the rubbing together of the surfaces of membrane when covered by thick soft layers of lymph. In many cases, too, this is not constant; it disappears after a few deep respirations, to reappear in the same place after an interval. In many of the insidious cases just referred to, friction is absent throughout; there is a large effusion of fluid with only a little lymph, and when the fluid is absorbed, the pleura retains its healthy condition.

Encysted Pleurisy.—Another very interesting case was that of a blacksmith, a tall, well-made man, aged 27, who, on admission, had absolute dulness with complete absence of breath-sound over the upper third of the left lung, and much fulness in that situation. Six months before admission, he had some hæmoptysis, and a little before that had suffered from slight cough and some failure of health; on the other hand, his aspect was not tubercular, and his family history was good. The physical signs were so marked as to give rise to a suspicion of malignant

growth, but there was no acute pain, swelling of the arm, or other sign of the pressure of a tumour. Dr. Peacock diagnosed encysted pleurisy, and, with the aid of blisters and tonics, the fluid was absorbed; some amount of consolidation, apparently tubercular, was left.

Empyema.—There were two cases of empyema, in both of which the fluid had been evacuated by the lungs. In one, a girl, about twenty-four years of age, the pus had also discharged itself externally, but the opening had healed quite soundly, the side was gradually contracting, the respiratory sounds were returning, and the young woman had improved greatly in health. The other was a boy, aged 10, who had been sent into the hospital for supposed pneumonia. Shortly afterwards, he suddenly expectorated, after a severe fit of coughing, a large quantity of pus; a considerable part of the previously dull area of his chest was now found to be somewhat tympanitic, and when he coughed there was a loud amphoric sound. Since then he had continued to expectorate pus at intervals, but the side was gradually contracting, the lung expanding, and the amount of fluid in the cavity was diminishing. Although pale, the patient was stout and lively; indeed, the trouble throughout had been to keep him quiet in bed.

Dr. Peacock remarked that, in cases of phthisis, the symptoms of perforation of the lung are often much less severe than one would expect. When it occurs in a case of early phthisis, whilst the patient is still in fair health, the symptoms are sufficiently well marked; but, in any more advanced cases of the disease, pneumothorax may supervene, with so little local pain and additional constitutional disturbance that its occurrence may be overlooked. In some cases, too, the escape of air and consequent effusion of fluid is limited by adhesions, rendering the physical signs very anomalous and puzzling. A sign which is always mentioned in books, and often the first which is given by a student under examination, is the peculiar sound produced by succussion; this is, however, a very uncertain sign, only met with when there is a considerable amount both of air and fluid in the pleural cavity, and when this cavity is tolerably free from adhesions. Dr. Peacock added that, although the prognosis of such cases as these is not very favourable in adults—permanent fistulæ being often the result—children generally do well. He has witnessed so many spontaneous cures that he does not, as a rule, advise an operation; if, however, the patient be distressed or greatly inconvenienced by the amount of the effusion, or if he cannot readily expectorate the matter, he would at once perform paracentesis; he prefers that the opening should be free and that the patient should wear a canula, or better still, that a counter-opening should be made and a drainage-tube inserted.

Speaking of *Pneumonia*, Dr. Peacock said that his experience of the disease as seen in London did not agree with what was generally stated, as to the rapid recovery of the patients and the complete disappearance of the physical signs in a short time. A sudden fall of temperature, indeed, does generally occur; but he finds that the physical signs usually clear off very gradually, and that evidence of a certain amount of damage to the lung often persists for a considerable time. The rapidity of the recovery depends also very much on the simple or complicated character of the case; after pleuro-pneumonia and broncho-pneumonia, convalescence is often very protracted.—*Brit. Med. Journ.*, July 20, 1872.

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Intracranial Tumours. — At a recent visit to the London Hospital we saw, under the care of Dr. Hughlings Jackson, several cases of intracranial tumour, or rather cases in which that diagnosis had been confidently made. One was that of a boy nearly nine years of age, who was supposed to have a tumour of the middle lobe of the cerebellum. A case very like it, in the life history, and in which tumour of this part was found, is recorded by Dr. Hughlings Jackson in this Journal, November 4th, 1871, page 528. In both cases, there was, at the beginning, irregular gait; there were double optic neuritis and enlargement of the head. The pa-

tient we saw at our recent visit is in an advanced stage, he lies on his back with his legs and feet extended, and with his arms flexed acutely at the elbows. There is, however, no drawing back of the head; there is no arching of the back; and his abdomen, although sunken, is not at all hard. The head is almost constantly turned to the left, as are also the two eyes. From this position he never moves, except that the eyes occasionally wander to the right. His head is not only large —strikingly above the ears—but it is evenly enlarged, for the sagittal suture gapes widely (no relics of rickets in his body). A tumour of the middle lobe, by pressure on the veins of Galen, will cause hydrocephalus. Mr. Hilton thinks that the cause of the common form of hydrocephalus is the result of closure of the cerebro-spinal aperture, which, according to him, is usually open. Possibly, then, in this case, the tumour closes this opening. But, whatever the mechanism may be, we see that, in an indirect manner, disease of the cerebellum can affect the cerebrem; there are mental symptoms in these cases. In a case closely like this in Guy's Hospital, many years ago, Sir Wm. Gull drew attention to the very general fading out of mind (a tumour of the middle lobe of the cerebellum was found, *post-mortem*, as Sir Wm. Gull had predicted). In the boy whom we saw, there is great apathy; he never speaks unless he be spoken to, when he replies correctly. He lies on his back in one position all day, never taking notice of anything unless directly addressed. But against this is to be noted the fact that he can sing. Mr. Stephen Mackenzie has heard him sing several songs; songs which he had learned when well, and which he used to sing at home. He sang for the class, and apparently with great interest, the first verse of "Up in a balloon."

In these cases, the intracranial pressure will be very gradually exerted (nervous matter bears slowly exerted pressure very well) and very evenly distributed—pressure by fluid. Thus we may account for the very general mental affection—the "fading out of mind." Power to sing is no very strong evidence of mental power. It is a largely automatic act. Aphasics can sometimes sing, and some idiots can. But it must be again remarked that the boy gives courteous and exact replies to simple questions; moreover he replies readily. In Sir Wm. Gull's case, towards the end of life, the interval before replying was so long, that a hasty observer would have supposed that the patient was deaf or entirely demented; but at length the reply came, and it was slow and monotonous. The absence of deafness in these patients is noteworthy. In cases of intracranial tumour, it is as important to note the almost constant absence of deafness as it is to note the almost constant presence of blindness (partial or total).

In the boy whom we saw, there have been no tetanus-like fits, as there were in the case recorded in November. From theoretical considerations, Dr. Hughlings Jackson has been led to suppose that the changes which cause the tetanic paroxysm and the interparoxysmal "set" of the trunk and limbs in tetanus are seated in the cerebellum, and not in the spinal cord, or not limited to it. But, since two such able observers as Lockhart Clarke and Clifford Allbutt have described changes in the cord in tetanus, he has refrained from fully stating this hypothesis. In the mean time, he diligently collects observations as to the tetanus-like affections, especially in the case where a gross (an obvious) lesion is likely to be found *post-mortem*, to fix approximately the seat of the minute changes causing the paroxysm. Hence the interest of the tetanoid fits in the case related in November. In some cases of cerebellar disease there is only a fragment of the tetanus-like condition.

There is (we may now say there was, for the patient died a few days after our visit) a woman, aged 52, who was plainly the subject of intracranial tumour. The double optic neuritis, the severe headache, and urgent purposeless vomiting, warrant this diagnosis. The doubtful questions were as to the position and nature of the tumour. She mostly lay in bed during her stay in the hospital, but when induced to walk, she "walked badly." Besides being quite blind, she was so dull and also so exceedingly timid and suspicious, that it

was difficult to make a more precise statement. She could not stand by herself; and it was particularly remarked that she fell backwards when left without support. Besides this, she was quite deaf of the right ear. These were the only localizing symptoms at first. Later, there was a nasal articulation, and the head was placed slightly to the left; her voice remained good to the last. It was supposed that the tumour lay under the tentorium, on the right side, so as to compress the auditory nerve. It was found, however, in the right posterior cerebellar fossa, or rather inserted, as it were, betwixt two flaps of the right cerebellar lobe, from which position it was detached—almost fell out—on removal of the brain. Whether the deafness was the result of indirect compression of the soft auditory nerve, remains doubtful. In such a case it is not worth while to speculate as to the relation of the falling backwards to disease of the auditory nerve or the semicircular canal, as there was a large tumour of the cerebellum. It would be unwarrantable to say that disease of the cerebellum itself produced the deafness—although the cerebellum does receive a larger share of the auditory nerve—because in most cases of cerebellar disease there is no deafness. But, again, it may be urged that the deafness was the result of an auditory neuritis. But, once more, tumour of the cerebellum is very rarely attended by deafness any way caused. Nothing is rarer, says Vulpian, than trouble of hearing in alterations of the cerebellum. (Of course, cases of abscess of the cerebellum from disease of the ear have no bearing on the question.) As to the nature of the disease, there were, at first, no doubts on the important question whether it was syphilitic or not, or rather, the style of the symptoms never suggested syphilis, and inquiries elicited no information about it. But about a month before her death, a nasal tone of voice led to an examination of her throat, and there was seen what was supposed to be an ulcer, on the back of the pharynx; "supposed," as, from her condition only a flying sight of it was to be got. On the chance of its being syphilis, large doses of iodide of potassium were given. At the necropsy, the pharynx was examined, and no trace of ulcer or cicatrix was found. The tumour was not syphylitic.

There is a woman in the Hospital aged 37, who is believed to be the subject of intracranial tumour. She has had headache, vomiting, and double optic neuritis. She was in the hospital just about a year ago; and the interest of her case is that both then, when the neuritis was in an acute or severe stage, and now she can read No. 2 of Snellen, although the changes in her discs have not even yet completely disappeared. It is, Dr. Hughlings Jackson says, extremely common for severe optic neuritis to exist when the patient can read the smallest type, and, what is more important, in some cases the changes pass away almost entirely—so far that a careful examination by the direct method is necessary to detect any abnormalities—when sight has never been affected. In short, occasionally there may be the pathological condition optic neuritis without the symptom amaurosis attending or following it.

The other day, a necropsy was made on a patient who had had hemiplegia of the left side, and also had, Dr. Hughlings Jackson supposed, optic neuritis on but one side, the side opposite the lesion. This is the second case in which Dr. Hughlings Jackson has seen uniocular neuritis from intracranial tumour; in that case, also, the tumour was in the side opposite the neuritis (case reported, *Royal London Hospital Reports*, November, 1871, p. 130, microscopical examination of both eyes by Dr. Hermann Pagenstecher).

There is a woman, aged 42, who has double optic neuritis, and also loss of smell—possibly owing to olfactory neuritis. There is no affection of taste in the strict sense of the word taste; at any rate, she can recognize bitters and sweets (quinia and sugar were used.) The existence of anosmia, Dr. Hughlings Jackson believes, does not warrant the diagnosis of disease actually involving or directly squeezing the olfactory bulbs, any more than optic neuritis warrants the diagnosis of disease actually involving or directly squeezing the corpora quad-

rigemina, optic tracts, or optic nerves. Probably, in most cases, the disease which causes the anosmia is of the anterior lobe; as to the optic neuritis (with or without defect of sight), it is of no value whatever in localizing, any more than "cerebral" vomiting is. When the class saw her last, she was reading; and on trial, when helped by convex glasses to correct her presbyopia, she could read, although badly, No. 1½ of Snellen. Nevertheless, her optic discs are much swollen, the arteries are not traceable, the veins knuckle over the edge of the swelling, and there are effusions of blood. She has other symptoms, and these localize. She has occasionally convulsions, followed by hemiplegia, and nearly complete loss of speech. These symptoms point to disease of convulsions of the left cerebral hemisphere. Although there is no demonstrable evidence of syphilis, syphiloma of the brain is most likely to be the cause of the symptoms; and as her convulsive seizures have varied not only in degree, but in kind, probably there is more than one focus of disease in the brain.—*Brit. Med. Journ.*, July 20, 1872.

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Treatment of Strangulated Hernia by Puncture of the Intestine.—The very great importance to surgical practice which the introduction of any plan for the treatment of strangulated hernia implies, induces us to refer to a method suggested by Mr. Bryant in a clinical lecture delivered at Guy's Hospital in the month of February of this year.

Mr. Bryant gave the details of a case which occurred to him in 1871. It was that of an old man, aged 71, the subject of strangulated scrotal hernia, upon whom he had performed herniotomy, it being necessary to expose the bowel in order to return it. Owing to the restlessness of the patient, however, the gut again descended in a few hours, and all attempts to reduce it failed, until the large intestine was punctured in four or five places with a grooved needle, and a quantity of flatus (but no fecal matter) let out. The patient recovered without a single bad symptom. In his subsequent remarks upon this case, Mr. Bryant observed that it proves clearly that puncturing the intestine freely may be resorted to with every prospect of success in some cases of hernia. He raised the question whether it is not possible to reduce some herniæ without any operation at all, and he stated that he had made up his mind to try the practice in large scrotal and umbilical herniæ, and thought favourably of its employment in all cases of acute internal strangulation due possibly to bands or twists.

Since the publication of this lecture the treatment of puncturing the bowel to remove strangulation has been followed in three cases (which are now well known), two of which have been published. The third occurred in the practice of Mr. Hulke, in the Middlesex Hospital, in the early part of May. The case was one of internal strangulation from a band, in which abdominal section was performed, and the distended small intestine punctured (ultimately laid open) before reduction of the bulging portions could be effected and the wound closed. This case, with Mr. Hulke's remarks, will shortly appear in our pages.

Of the two published ones, one was reported by Dr. Léon Labbé, of the Hôpital La Pitié. It was a strangulated inguinal hernia, of about eighteen hours' duration, in an old man, aged 70. Here, as the taxis failed, puncture with the aspirator was proposed, and a No. 2 needle introduced. In eight days the patient was well. The other case was one brought before the Académie de Médecine, on May 21, by M. Demarquay, full details of which will be found in the *American Journ. Med. Sci.* for July last, p. 267.—*Med. Times and Gaz.*, Aug. 3, 1872.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

The Current Materia Medica.—Dr. E. R. Squibb made some interesting remarks before the New York Academy of Medicine (June 20th, 1872), from which we extract the following:—

The various *extracts of meat* sold at the stores are of little value; there is not one of them, which is advertised, which

will bear out the remark of Dr. Christison, "they arrest waste, but do not keep up the supply." His impression is, that there is not as much against the use of solid food or aliment in disease as has been said against it. The stomach is not a chemical laboratory, "a kitchen for cooking food," as Abernethy wisely remarked. Food should not be subjected to the ordeal of chemists, as the fashion is.

Among the articles that have been introduced in the dietary department, and have taken a firm stand in the materia medica, is *pepsin*. Generally, however, patients have been in the habit of taking starch rather than pepsin. Once get up a reputation concerning a certain variety of this agent, the manufacturer has a good start for making money. Some specimens examined were good and others bad. The name of the maker is no guarantee, as it may be good at one time and poor at another. While the proprietor is looking after the money column, the manufacture is entrusted to another. The fresh supply of pigs' stomachs must come from the western pork-markets.

The pancreatic emulsions and preparations of bismuth and pepsin, so fashionable now, cannot be recommended: bismuth and pepsin cannot exist together. Those fashionable mixtures of beef and iron—as Vinum cibi, Vinim cibi et ferri cum cinchona, etc.—are gross frauds; only money is in them. Hardly any cod-liver oil will pass muster except it is tasteless; and his impression is that many of these preparations are not cod-liver oil at all, only oil made up for the market. Good oils should neither be too dark nor too light, but of a medium colour. The dark varieties are made of livers in a state of decomposition. There are good cod-liver oils in market which come from Norway and Newfoundland. The reason that the Norwegian oil is less rancid than others is, because it is never made at a less temperature than fifty degrees; consequently decomposition is avoided. Oil, when in use, should be kept in a cool place, as a refrigerator, and after each dose is given the glass should be thoroughly washed. Small pieces of ice put in the doses of disagreeable substances, like cod-liver oil, render the agent almost tasteless. Those physicians who eschew the fashionable remedies take to the syrups, such as Aiken's syrup, etc. The lacto-phosphate of iron is based on fallacies like the others; but it is very taking, and is advocated by Horsford and others. Physicians are anxious to get solutions of phosphorus into the stomach, but before it gets there it becomes oxidized.

Another popular fallacy of the day is the use of sugar-coated pills or medical confectionery. Coroners have found these pills, after death, in the stomach and intestines, undissolved. Medicines should be given in such a shape that they will be quickly dissolved. It is not an easy matter to get the hard coat off the pills. Glycerin should be used in compounding pills, to render them soft. Pills made in this way are easily dissolved in the stomach. He has been astonished that Blancard's pill has been so useful as has been stated—it being covered with a metallic coat.

Medicines in capsules are not to be advocated—they being not easily dissolved.

The use of various forms of divided medicines, particularly "The Divided Medicine Co.'s" preparations, is another fallacy. It is nothing new, but an old way of preparing medicines. This way of dosing might be good if the physician would put the medicine up, but to purchase these preparations of companies is dangerous pharmacy. * * *

Condurango, which received its aid from the State Department at Washington, D. C., has pretty much gone out. That department deserves the reprobation of the physicians of this country. Reports have come back to the discredit of its use.

Nitrite of Amyl, introduced by the foreign physicians, and first written about by Dr. Richardson, of London, is a useful remedy. Cases of hemicrania, spasmodic asthma, etc., have been relieved by its inhalation. It is supposed to paralyze the nervous system of the arterioles; from sixty-five to seventy beats may be added in a few seconds by its use. The circula-

tion resumes its usual tone in a few minutes, and the effect of the remedy passes off.—*Medical Record*, Aug. 1, 1872.

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Galvanic Treatment of Bed-sores and Indolent Ulcers.—Dr. Wm. A. Hammond, of New York, recommends for indolent ulcers and bed-sores, the galvanic treatment as first suggested by Crussel, of St. Petersburgh. He says: "During the last six years I have employed it to a great extent in the treatment of bed-sores caused by diseases of the spinal cord, and with scarcely a failure; indeed, I may say, without any failure, except in two cases where deep sinuses had formed, which could not be reached by the apparatus. A thin silver plate—no thicker than a sheet of paper—is cut to the exact size and shape of the bed-sore; a zinc plate of about the same size is connected with the silver plate by fine silver or copper wire six or eight inches in length. The silver plate is then placed in immediate contact with the bed-sore, and the zinc plate on some part of the skin above, a piece of chamois-skin soaked in vinegar intervening. This must be kept moist, or there is little or no action of the battery. Within a few hours the effect is perceptible, and in a day or two the cure is complete in a great majority of cases. In a few instances a longer time is required. I have frequently seen bed-sores three or four inches in diameter, and half an inch deep, heal entirely over in forty-eight hours. Mr. Spencer Wells states that he has often witnessed large ulcers covered with granulations within twenty-four hours, and completely filled up and cicatrizations begun in forty-eight hours. During his recent visit to this country I informed him of my experience, and he reiterated his opinion that it was the best of all methods for treating ulcers of indolent character and bed-sores."

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Apparatus for Inhalation of Eucalyptus.—Dr. Stout exhibited to the San Francisco Medical Society an apparatus for the inhalation of medicated vapours. The medicated liquid is kept boiling by a spirit lamp and the vapour conducted through a tube. He had used the eucalyptus in this way, employing the tincture mixed in water. It was preferable to the common atomizer, because of the warm vapour, which is not only medicinal in itself but promotive of absorption. The eucalyptus he had found very beneficial in bronchial and pulmonic affections. Dr. Stout also distributed some *cigarritos* made by inclosing the powder of the leaves in a roll of paper, which were puffed by the members with apparent satisfaction.

Dr. Pigné-Dupuytren testified to the virtues of eucalyptus, which had been fully tested by himself and Dr. D'Olivcira, in the French Hospital. It had been found highly serviceable in affections of the larynx and of mucous membranes in general; also as a tonic.—*Pacific Med. and Surg. Journ.*, Aug. 1872.

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Successful Ligation of Right Carotid Artery for Aneurism.—Dr. Pigne-Dupuytren exhibited to the San Francisco Medical Society a patient on whom he had performed this operation. The aneurism being on the right side and so near the innominate artery, it became a nice point to decide where the ligature should be placed, that it should not be too near the innominate to prevent the formation of a clot, or upon the diseased artery where a similar difficulty might arise. The ligature came away on the 17th day. In five months the tumour had entirely disappeared.—*Ibid.*

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Total Rupture of the Intestines from injury without any external evidence.—A very interesting case of this is related (*Pacific Med. and Surg. Journ.*, Aug. 1872) by Dr. Edwin Bently, Ass. Surg. U. S. A. A boy six years of age was accidentally crushed between the tail of a wagon and a board fence. He was taken up apparently fainting; stimulants were at once administered and he appeared to rally. The clothing being removed the body of the little fellow was carefully examined by an intelligent physician. No abrasion or bruise could be found over the entire surface, nowhere could tenderness be detected, and it was hoped the accident was not very serious. A suitable diet was directed,

and the stimulants continued, in expectation that with reaction from the shock and fright convalescence would ensue, or the severe features of the injury would become manifest. The first night was attended by a reasonable amount of repose, and on the following day, aside from the extreme paleness and anxious countenance, but little concern was apprehended. The second night was more restless, and constant nausea and frequent efforts at emesis occurred. The third morning it was noticed that the urine had been abundant, but no fecal discharge had taken place since the accident. Repeated cathartics were administered, but only to be returned like everything the stomach received. He was able to bear his weight upon his limbs, and even to walk. It was thought evident that no bones were broken; the impression prevailed that if an evacuation could be obtained, the vomiting would be overcome, and little else would be needed; for the usual attendants of inflammation were not apparent, heat, pain, redness, and swelling were nowhere found. Purgatives in various forms were repeated. Yet nothing was retained; enemas were freely administered, to as little purpose. The third night the boy expired.

On post-mortem examination a few ounces of fluid was found in the cavity of the peritoneum; the serous coat of the small intestines was agglutinated together in patches; the ileum was ruptured in three places, and in one place, about ten inches from the ileo-cæcal valve, was completely separated; the calibre of the intestine being torn asunder.

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Summer Heat of 1872.—The records kept at the Pennsylvania Hospital show the temperature during June and July has been unprecedently high. The mean temperature for June was 76.62 degrees, within three-quarters of a degree of the highest ever known since the record has been kept, and for July 82.31, the highest ever recorded. Usually when June or July has been extremely warm, the preceding or succeeding month has been quite temperate, contrary to what has occurred the present summer. In this respect, as well as in the unparalleled heat of July, the present summer has been the warmest on record in our vicinity.

During the month of July, 11.22 inches of rain fell, a quantity never exceeded but once previously, and then by only half an inch. Rain fell on eleven different days of the month, the heaviest fall being on the evening of July 4, and measuring 3.13 inches, while the average rain fall of the month during the past thirty-five years has been only 4.08 inches. During the first six months of the present year 18.24 inches of rain fell, making a total of 29.46 inches, against 28.26 inches during the first seven months of 1871.

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Long Island College Hospital.—Dr. Wm. Warren Greene has been appointed Professor of the Principles and Practice of Surgery and Clinical Surgery in the above school. Dr. G. enjoys a high reputation as a skilful surgeon.

FOREIGN INTELLIGENCE.

Hydrate of Chloral in Hooping-Cough.—Dr. Karl Lorey reports (*Deutsche Klinik*, 46, 1871) the results which he has obtained from the use of chloral hydrate in pertussis. He gives it in the following formula: Hydrate of chloral 5 parts, distilled water 150 parts, syrup of orange-peel 15 parts. The dose is from one to three teaspoonfuls, according to the age of the child. Generally, one teaspoonful is given in the morning, and one or two in the evening. The medicine is commenced as soon as the earliest characteristic symptoms appear, and is continued until the cough loses its catarrhal character. It is borne well by children, and produces no unpleasant consequences. It produces a marked reduction in the number and intensity, as well as in the duration, of the paroxysms.—*Brit. Med. Journ.*, July 20, 1872, from *Wiener. Med. Wochenschr.*, June 15.

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Nervous Sequelæ of Enteric Fever.—Dr. Nothnagel has collected a number of notices of affections of the nervous system following enteric fever, and has published an interesting essay on the subject in the

Deutsches Archiv. für Klinische Medizin. In most cases where these disorders are met with, they consist of paralysis of motion and sensation; while, along with the diminished cutaneous sensibility, there may be severe pain. Paraplegia is the most common form; it is generally limited to the lower limbs, but sometimes one of the upper limbs is also affected, or there may be slight paralysis of both arms and legs. Much more rarely, one limb alone is affected, or one upper and one lower limb on opposite sides; and sometimes the paralysis is limited to parts supplied by special nerves or branches, especially the ulnar and peroneal nerves. Disturbance of the sensory function is more frequent than of the motor; assuming the form of hyperæsthesia or of anæsthesia, being generally limited in extent, and affecting the lower limbs, especially the feet. Neuralgia without paralysis, motor paralysis of the parts supplied by the cranial nerves, disorders of the optic nerve, and vaso-motor disturbances, are of rare occurrence. The actual pathological condition producing this disorder is not yet known; but Nothnagel is inclined to attribute the paralysis of enteric fever to the same cause as the paralysis following diphtheria, which, according to the researches of Oestel and Buhl, is dependent on diphtheritic infiltration (cell-proliferation) in the sheaths of the nerves and between the fasciculi, as well as among the ganglion-cells of the sensory nerves.—*Brit. Med. Journ.*, July 20, 1872.

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Thoracentesis in Empyema.—M. Sedillot, in a discussion on this subject at the Academy of Medicine (June 25th, 1872), showed that the Hippocratic school had perfectly apprehended the indications in empyema, and made, in the therapeutics of this disease, the judicious application of most of the modes of treatment which are advanced, at the present day, as novelties.

He might have said the same of many other therapeutic and surgical measures which are often put forth as new, but which were well known to the fathers of medicine, and their value properly appreciated; but which have been overlooked by their successors, and from time to time are revived by those who have more inventive talents than learning.

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Treatment of Imperforate Anus.—Amongst the operations that may at any moment present themselves to the surgeon, that required for the relief of imperforate anus is one of the most delicate and important, and he should be prepared to meet any difficulties that may present themselves. "We too frequently neglect," says M. Verneuil, "to ask whether the newborn infant has evacuated the urine and meconium; and when it is ascertained that the anus is imperforate, much valuable time has been lost." Thus, he has himself been called upon to operate on the fourth day. He observes that the success of the operation has been made greater in recent times, when, instead of pushing a trocar at hazard in various directions, deliberate dissection has been made. This is particularly requisite where there is no projection of the rectum, or where the inferior extremity of the rectum is altogether absent. A convenient place should be selected, the infant on its belly, with the knees bent and thighs well separated. An incision should then be made from the easily found point of the coccyx, along the median raphé towards the scrotum or vulva. It is important to keep in the middle line, where we find always, as we are taught by embryogeny, in the absence of the rectum, a fibrous band which runs as far as to the membranous region or inferior third of the vagina. This is a valuable guide that must not be lost. When the incision made *layer by layer* is sufficiently deep, then may be perceived, on separating the cut edges of the wound well from each other, and directing a jet of cold water upon them, a small black point not larger than the head of a pin. This is the intestine, and if it be movable it should be drawn towards the skin. It is a fortunate circumstance when this can be done without opening it. More frequently it is only possible to seize the end of the intestine with the hook, and an incision is then made into it. The meconium then flows away, and begins at once to be a source

of trouble; its flow sometimes lasts for a considerable period. It must be watched with patience, and waited for till it has finished, in order to complete the operation, which consists in sewing the rectum securely to the skin, taking care that the opening is free, and that there are no chances of retraction or of infiltration. But it may also happen that a deep incision may be made into the perineum, and nothing may be found. The situation becomes a grave one, for it is necessary to continue the dissection into the true pelvis. The operation is difficult, and the guides to it obscure. Not unfrequently the absence of the rectum exists for a considerable portion of its extent. To keep straight in this course across the pelvis, it is important not to lose the walls, the curvature of the sacrum in particular, which is a valuable guide. It is, nevertheless, attended with much difficulty, and M. Verneuil has suggested a proceeding which materially facilitates it. It consists in giving a cut with the scissors on each side of the coccyx, which can then be drawn back, and at once affords greater space to work in. In one instance M. Verneuil found a cut of a quarter of an inch long on either side sufficient, but in others it is necessary to make the incisions nearly a quarter of an inch. He has thus succeeded in cases where otherwise the operation would have had to be given up, and some other attempted. Once formed, the retraction and contraction of the new anus should be prevented by directing the mother to introduce the point of the little finger into it several times a day. Most of the cases of imperforate anus prove fatal.—*The Practitioner*, Aug. 1872, from *Journal de Médecine et de Chirurgie*, tome xliii. part 2.

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Operation for Harelip; the Cicatricial Contraction prevented by collodionized Strips of Wadding.—A case of harelip was reported in the *Gazette des Hôp.* (June 8), as illustrating M. Broca's employment of collodion. He practises the operation upon infants at the breast, securing union by silver threads, which he removes as soon as possible—the fifth, fourth, and often the third day. He does this not only from fear of threads cutting through the tissues, but because suppurative inflammation set up around them may extend to the edges of the wound and disunite them; several examples of which he has seen. But a three days' cicatrix is not very solid, and cannot be relied on, seeing that the lips are exposed to much traction, especially during the cries of the child. This traction may be much diminished if, after the removal of the wires, a small portion of wadding is wetted with collodion, and spread (bringing the cheeks of the child together at the same time by bilateral pressure) out above the lip, stretching out on each side like a moustache. When the ether has evaporated, not only does this layer of collodion adhere closely, but it retracts, just as collodion does, without the wadding; and the lip is in this way supported and protected from all separation. These collodionized strips of wadding are also of great use in diminishing the size of suppurating wounds and their consecutive cicatrices by reason of the sliding or "mobilization" of the surrounding skin. M. Gosselin applies the same principle also in lesions of the lower eyelid, the cicatrices of which may give rise to ectropion, by exercising repeated pressure on the cheek from below upwards, pushing up the skin towards the eye. It acquires by this kind of shampooing a degree of mobility that may prevent the eversion of the eyelid.—*Med. Times and Gazette*, July 13, 1872.

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Surgical Affections of Adolescents.—M. Gosselin, in a memoir read before the French Academy of Sciences, sought to show the influence exerted by the age of the patient in the choice of the means of treatment.

"For determining this choice," he says, "I offer the following formula for our guidance, viz.: 'The special spontaneous surgical affections of young persons have a tendency to persist, increase, or relapse, as long as the period of adolescence lasts; but these tendencies are lost as soon as adult age is reached.' Thus—1. In *Ingrowing nail* many are the remedies that have been recommended, and yet new ones are always being sought for, because, after

using those hitherto employed, relapse has ensued. Now, most frequently this depends upon the fact that the subject, being still young, retains the special pathological aptitude through which the disease was originally produced. For my part, I have never had occasion to observe relapse after the 25th year, and from this I conclude that, while we should take every care to prevent the return of the disease, we must not expect a definite cure as long as the patient has not reached his 23d or 24th year.

"2. In *valgus douloureux*, which I have also named *tarsalgia*, I have established that the disease depends on a special arthro-osteitis of the tarsus, developing itself as a consequence of the growth of this part of the skeleton; and that the chief indication consists in relieving the pain in walking and the concomitant contraction of the muscles of the leg, and thus preventing termination by muscular retraction, permanent valgus, and anchylosis. The best means for obtaining these results are rest, *inamovible* apparatus, and sometimes tenotomy of the lateral peronei and electricity. But as long as the patient remains young, relapse is not always avoidable. When it does occur we must return to the employment of the same means, and not conclude too hastily that the disease is incurable; for by persevering in the treatment until the subject has attained the adult age we may prevent the consecutive deformity and infirmity which would ensue if the affection were left to itself.

"3. In *acute suppurating osteitis of the epiphysis*, when this has not been intense enough to call for primary amputation or to cause death, and when it has terminated by necrosis of long duration, I recommend that consecutive amputation should not be too readily determined upon; for in such cases I have seen the necrosis terminate and a definitive cure ensue, when the patient having reached his 25th or 26th year, has lost his predisposition to suppurative osteitis, which was a consequence of his age and an aberration of nutrition at the period of the juncture of the epiphyses.

"4. In *exostosis of the epiphyses*, or exostosis of development, my observations have taught me that the tumour ceases to grow and be painful when the subject has once passed adolescence; and, as its removal is a dangerous operation, I advise temporizing and leaving the affection to itself.

"5. In *subungual exostosis of the great-toe*—an affection too troublesome and too painful to allow of non-interference on the part of the surgeon—the relapses which follow their employment constitute the objection to most of the measures that have been proposed for its removal. But here, as in in-growing nail, I have found that, although relapse occurred while the patient still continued young, it ceased when once adult age had been reached.

"6. In *large fibrous naso-pharyngeal polypi*, the dimensions of which do not allow of their being treated even in a palliative manner without a preliminary operation affording access to their seat of implantation, this consideration regarding age is of primary consequence. I reject the excision of the upper jaw because it endangers life and leaves a mutilation of the face without assuring in an absolute manner against relapse. I prefer M. Nélaton's procedure—an aperture in the velum and arch of the palate—contenting myself with palliative operations by excision and cauterization, thus preserving the patient's life until the time when, being of adult age, he will in all probability have lost the disposition to reproduce the tumour."—*Med. Times and Gazette*, April 20, 1872.

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Removal of Naso-Pharyngeal Tumour.—In order to gain access to the posterior nares and pharynx for the removal of tumours, Dr. von Bruns, of Tübingen, operates in the following way. A horizontal incision is made along the upper lip (of a sufficient height to avoid wounding the mucous membrane) from a point a few millimetres below the right ala nasi to the level of the first molar tooth; a second incision is then made along the naso-frontal suture; and a third is curved obliquely down on the left side to the end of the lower incision. The base of the nasal spine is divided by a saw, and the

septum is cut through by bone-forceps; after which the bony parts are carefully sawn, and the right nasal bone is raised from its union with the maxillary. The whole nose can then be turned over on the right cheek, and replaced after the removal of the tumour. Or half only of the nose may be treated in the same way, by making the division between the nasal bones, and leaving the septum and the parts on the sound side uninjured. Dr. von Bruns has employed this method in three cases. In one of them, it was necessary to keep the nose displaced for three weeks; but at the end of that time, after the edges had been freshened, union rapidly took place. He says that this operation facilitates the removal of tumours and the arrest of hemorrhage; that it gives the surgeon the opportunity of watching the parts for some time, so as to perform any further operation that may be necessary; and that recovery takes place soon, and without any impairment of function. — *Brit. Med. Journ.*, June, 1872.

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Fever and the Sewers.—[That sewer emanations are deleterious to health we are not prepared to deny; but we may state that we have some doubts as to their being the sole cause of the diseases ascribed to them, and it seems to us yet to be proved that such gases were the cause of the typhoid fever which afflicted the Prince of Wales some months since. The following statement seems to support these doubts.]

After all that has been said at the time of the Prince of Wales' illness, the public will be glad to learn, on authority, that the men employed in the sewers are not only not carried off by fever, but appear singularly free from the ravages of that disease. At the instigation of Dr. Brewer, the Metropolitan Board of Works ordered a return on the subject, which has just been issued, and is quite conclusive.

Out of 5 inspectors employed from 23 to 48 years, there has never been a case of fever. Out of 64 men employed in cleansing and flushing the northern sewers for periods varying up to 34 years, only 2 have had fever, and their cases were typhus. Out of 47 men engaged in the sewer work in the southern sewers for periods varying from 1 to 24 years, there have only been 2 cases of fever, and these again typhus, and in one of these cases it is shown that the disease was contracted from the man's family. There are 36 penstock and flap-keepers who have been employed from 1 to 50 years. Of all these, only one has had any fever. He has been 16 years at work, and had typhoid in 1862. There are some curious notes about these men. One of them has been at this work 50 years, and has not had one day's illness during the time. One lived 25 years in the sluice house over the King's Scholars pond sewer, but never had any fever. Another lived for 14 years in Penstock House, over outfall sewer at Old Ford. Another lived 32 years in Great St. John's sluice house. Another lived for 35 years in a house over Duffield sluice, and enjoyed good health. Out of 54 men employed at the pumping stations, there has only been one case of fever (typhoid).

At Crossness, out of 54 men engaged during the last 6 years, there has not been one case of typhus or typhoid. There have been 8 cases of ague, but these are of course due to the low marshy district, and they seemed to have recovered rapidly. Out of 7 men employed in cleansing ventilators, oiling side entrances, gauges, &c., no case of fever has occurred, though one man has been at the work 23 years. Of 10 surveyors and chainmen in the engineer's office, not one has ever had typhoid fever, although they have been almost daily engaged in the sewers for periods of from 4 to 24 years.

These facts are very gratifying, and quite dispose of the allegation that the men in the sewers are decimated by fever. The statistics show, in fact, that fever is less prevalent amongst these men than the rest of the town population.—*Dublin Med. Press and Circular*, April 10, 1872.

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Recent Epidemic of Variola at Leipsic.—Prof. Wunderlich states (*Archiv der Heilkunde*) that smallpox has prevailed more severely at Leipsic than in other places in Germany during the recent epidemic, and that in consequence of the

great neglect of vaccination and revaccination which has ensued upon the agitation of the so-called "nature-doctors." Until recently epidemics have been very few, and attended with a very slight mortality. During the years (1852–69) that he has been Director of the Municipal Hospital, there have been admitted 663 cases, furnishing only 29 deaths; and during the years 1868 (when the cases increased to 150) and 1869 (when they were 108) the deaths were only 10 and 3 respectively. The deaths almost exclusively occurred among the non-vaccinated; for while the general mortality from the disease was 4¼ per cent., that of the unvaccinated was 33 per cent. It was not until quite the end of 1870 that the epidemic seemed to be taking on large proportions, but from then to February, 1872, 1727 cases have been admitted; and although the number of admissions has gradually diminished since July, 1871, the epidemic can scarcely be regarded as terminated. Of course temporary hospitals (in the form chiefly of sheds) had to be provided, and among other contrivances the erection of a "station" for *suspected cases* proved of great value, as it had done formerly in cholera outbreaks. Many cases were sent to the hospital as smallpox, in which the diagnosis was not confirmed; others, which in the hospital were yet doubtful, were transferred here, so that they might be watched; and they were either discharged or returned to the hospital as the course of the disease indicated.

Of the 1727 patients 139 had not been vaccinated, 22 had already had variola, 1504 had been vaccinated, and of 62 no account could be got. In 79 revaccination had been performed, giving rise to pustules only in 13. The large proportion of the cases occurring in the vaccinated must excite surprise; but in point of fact a small proportion only of the population is unvaccinated; and infants, who constitute the great proportion of cases in the unvaccinated, are only brought to the hospital in direful emergencies. The present epidemic has been remarkable, not only for the number of cases, but for its great fatality. While during the last eighteen years the mortality from smallpox has averaged 4¼ per cent., in this epidemic it has nearly reached (253 deaths in 1727 cases) 14.7 per cent.; and, making allowance for some of the deaths being due to other causes, the fatality has at least tripled itself. Of the 139 unvaccinated there died 99, or 71 per cent.; and of the 62 in whom it was doubtful whether vaccination had been performed, 32, or 51½ per cent., died. Of the 22 persons who had smallpox for the second time, 6, or 23 per cent., died. Of the 1504 vaccinated, 116, or $7\frac{7}{10}$ per cent., died. None of the 13 successfully revaccinated died. As the epidemic diminished, the mortality became not only absolutely but *relatively* less. The observation applies during the whole eighteen years over which this account ranges, that the relative mortality is increased with the number of cases. Thus, with 168 in 1857, it was 5 per cent.; and in 1868, with 150 cases, 6½ per cent.; while in the fifteen other years, during which the cases averaged 22, it was only 3⅔ per cent. In the present epidemic it has reached 14.7 per cent. *Sex* exercised little influence on the mortality, but a very different account is to be given of *age*. Of 116 children under 15 years of age there died 73, or 63 per cent.; while of 1611 persons above that age there died 184, or 11⅓ per cent. The contrast is still more remarkable in unvaccinated infants. Of 29 such under 1 year, 27 died. and of 31 under 2 years, 27 died. This influence diminishes in the third year, when of 15 unvaccinated, only 8 died; and of 23 between 4 and 8 years, only 7 died. The effect of vaccination in early life is strongly brought out by the fact that not a single vaccinated child of 8 years or under was brought to the hospital. The number of unvaccinated children of this age amounted to 100, and of these 69 died.

As still further illustrating the benefits of vaccination, it is stated, that, while, of 11 unvaccinated between 9 and 14 years, 4 died, none of the 20 vaccinated died. Between the years of 15 and 25 there were 11 unvaccinated with 4 deaths, and 801 vaccinated with 23 deaths. Of the 18 unvaccinated above 25 the whole died, while the mortality of the 671 vaccinated

amounted to 14 per cent.—*Med. Times and Gazette*, July 20, 1872.

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Death from the Sting of a Bee.—On the 19th of July, a female, aged fifty-five, was stung by a bee behind the ear. Shortly afterwards she became unconscious, and died before the doctor who was sent for arrived. The brother of the deceased stated at the inquest that she was of a delicate and nervous constitution. In the autumn of 1870 she was stung by a bee, and the consequences were very peculiar. She became unconscious, and remained in that state for two hours. It is well known that many people endure far greater sufferings than others when stung by bees or other insects, and cases in which serious consequences have ensued are recorded. Beck, in his work on Medical Jurisprudence, quotes a case where a sting on the back of the finger was quickly followed by "vomiting, sweating, trembling, and great difficulty of breathing."

Dr. Tanner quotes a case from the *American Journal of the Medical Sciences*, of a man who suffered very seriously in the month of August, 1819, from the single sting of a bee, and who being stung a second time (on the temple) in the following year, died from the effects thereof within ten minutes. Two or three other cases of fatal result are quoted by the same author, but happily such an occurrence is exceedingly rare. The advice given by the coroner, Dr. Diplock, to "give stimulants freely" in such cases, is undoubtedly founded on sound principles, the immediate cause of death being apparently failure of the heart's action.—*Lancet*, July 27, 1872.

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Coup de Soleil.—Several cases of sunstroke were admitted last week into the London hospitals. The only fatal case, so far as we know, occurred at St. George's Hospital. One of the boys belonging to the *Goliah* training ship was struck down just after being reviewed by the Prince of Wales, in the Horticultural Gardens on Thursday week. He was brought to the hospital, and died in a few hours in spite of treatment; his temperature before death exceeded 109°. The necropsy showed nothing but very fluid blood and a somewhat congested brain; the lungs and other organs were healthy. The absence of prodromata is remarkable in these cases. A strong-looking labourer of middle age was admitted also into St. George's Hospital on the 26th. He had been at work all the morning, and became suddenly unconscious just as he was going off to dinner; he declared that he had not been at all inconvenienced by the heat, had taken nothing to drink, and felt perfectly well till the moment of the attack. That "precaution is better than cure" is no doubt a stale and trite proverb; but in this, as in many other instances, it is as true as it is trite.—*Brit. Med. Journ.*, August 3, 1872.

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Effects of the great Heat in England.—In England, as well as in this country, the heat of the summer has been unusually great, and there as here has resulted in increased mortality. In the *Lancet* of August 3d, it is stated that in London the general mortality has risen from 17 to 26 per 1000 in the last five weeks, the rate last week (26) being higher than in any previous week this year, a result almost exclusively due to the fatality of diarrhœa, which caused last week 394 deaths. The mortality from this cause was nearly all among children under five years of age, of whom 324 died in their first year. In the eighteen large towns the deaths registered from diarrhœa in the week ending 6th July were 113, in the next fortnight they were successively 226 and 370, and last week 604. In Leicester and Leeds the fatality is greater than in London, while in Hull it is equal, but in all the other towns considerably less fatal than in London. The Registrar-General refers in this connection to the "importance of pure water to children who drink freely in hot weather," and no doubt that is a most important matter; but it must be remembered that the mortality is to a large extent among infants, who are hardly likely to drink freely of water.

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GUERSANT ON SURGICAL DISEASES OF INFANTS, ETC. 8 PAGES.

CLINICS.

CLINICAL LECTURES.

Clinical Lectures on Strangulated Hernia. Delivered at St. Bartholomew's Hospital. By Sir JAMES PAGET, Bart., V.P.R.S., Consulting Surgeon to the Hospital. (Continued from page 143.)

LECTURE II.—In the last lecture, I tried to show how the signs of a hernia supposed to be strangulated may be used for guidance in determining whether its reduction must be achieved by operation, or whether any simpler means for reduction may be used. In this lecture, I will speak of the trials at reduction that may be made, or may not be made, before operating.

For a general rule, let me repeat, your first examination of a patient with a hernia supposed to be strangulated should not be with a design to reduce it at once, but rather with a design to make out what shall be done; what are the chances of reduction without operation; what helps shall be used to obtain it, if it be deemed desirable. Of course you may reduce the hernia, if reduction at once be easy; but do not go on trying if it be difficult. If the case be a bad one, you must first decide whether reduction without operation should be even attempted; and, if the attempt is to be made, what and how much it should be. For this decision, here are some general rules, which I find illustrated by my cases.

In very bad cases—as, for instance, when the patient vomits fecal matter and has peritonitis, or is in collapse, with a small rapid pulse, hiccough, or other such

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extreme signs—there should be no attempt at reduction without operation. The risk of the operation is trivial in comparison with that of returning sloughing or ulcerating intestine into the abdominal cavity.

When the coverings of the hernia are so inflamed as to make it probable that sloughing or suppuration has taken place beneath them, reduction should not be attempted without operation; and, even when they are less inflamed, none but very brief and very gentle efforts should be made, for success is improbable, and failure may be mischievous.

The longer the signs of strangulation have existed, the shorter should be the efforts at reduction; and the more acute the signs are or have been, the more gentle should these efforts be. Only here, do not reckon among the acute signs the intensity of pain in recent or greatly enlarged herniæ; for many of the most intensely painful herniæ are reducible with the help of chloroform, though they may need as much force as in any case justifiable.

The longer and the more numerous and forcible the efforts at reduction made, in any case, before it comes under your care, the briefer and gentler should your own efforts be; if, indeed, you do not at once decide that enough has been done, and that there remains no fair chance of reduction without operation.

If you find that you have to do with a hernia which has been habitually irreducible, and in which you have reason to believe that, without any addition to them, the contents of the sac have become strangulated, you had better operate at once. You are not likely to reduce a protrusion which even before strangulation was irreducible.

Let me now suppose that, observing these rules, a first examination of a strangulated hernia leads to the decision that its reduction without operation is to be attempted: I cannot give a single rule of practice that shall always suffice for the next step after such a decision; but, speaking generally, and of a great majority of cases which come under treatment, it is a safe rule of practice that, after a very warm bath and a few hours' rest in bed—say from three to twelve hours, according to the case—a single attempt at reduction, of reasonable force and length, should be made; that, if this should fail, chloroform or ether should be given; that then, in some cases, but not in all, a second attempt should be made; and that, if this should fail, or if it should not be made, the operation should be performed while the patient is still insensible.

The hot bath should be used in all cases that are not very bad, unless in old and feeble persons, whom it might depress too much. Among these, its place may be supplied by very hot fomentations, or by warm poultices over the hernia and the parts near it; and these must be used as the next best things when a hot bath cannot be had. Helped by rest, all these things are certainly very useful, whether by relieving the tendency to irritable muscular action, or by relieving congestion, or by whatever other means. Especially you may see their utility in hospital patients, who are commonly brought in wretched, chilled, and restless, with their herniæ tense and full and very painful, and their abdominal muscles starting into resistance at the least painful pressure. The heat of the bath, and bed, and recumbent rest, may remedy all this; and the hernia may become easily reducible, or may even reduce itself. It is commonly advised to have the bath so hot, and to keep the patient so long in it, that he may be very faint; and during this faintness to attempt the reduction while the patient is still in the bath. I more than doubt the prudence of this advice. It seems to me better to let the patient be simply soothed and relaxed in the bath, then to put him into bed wrapped in warm blankets, lying on his side, on his back, with his knees drawn up, or with his pelvis a little raised, and then, after an hour or two of complete rest, to attempt the reduction. The advantage of this plan is shown in the many cases in which the surgeon gets the credit for reducing a hernia which the house-surgeon has failed to reduce. The house-surgeon tries in the bath, and fails; the surgeon, an hour or two later, succeeds, not, or at least not always, by greater skill, but by reason of the more

favourable condition of the patient after a time of rest and warmth, and of his better position—lying flat, instead of half-sitting as in the bath. This employment of rest and the bath may be helped by opium whenever the hernia is very painful, and the patient too restless to have a chance of natural sleep. A grain of opium may procure the rest necessary for the quietude of the parts, but is less likely to be useful with femoral than with umbilical herniæ, and less likely with these than with inguinal.

In the old, and in others who may have had inactive bowels long before the strangulation, and in whom fecal accumulations or abundant air may be in the large intestine, an enema even of a large quantity of liquid should be used; for the emptying of the large intestine may greatly facilitate the return of the hernia. Purgatives, I believe, had better not be thought of, if there be any marked signs of strangulation. There are no clear indications for determining the cases in which they might possibly be useful; and, if they do no good, they may do grievous harm. I do not doubt that some have gained advantage from purgatives; but in my notes and memory I rather find instances of mischief, and certainly no cases in which there seemed reason to think that the patients were the worse for not taking any sort of purgatives after evidence of strangulation.

After the warm bath and rest—and still speaking of only the majority of cases, for in some there is no time for these things—you may give chloroform or some other anæsthetic, and try to reduce the hernia. How you are to do this, I cannot tell you now; nor what time and force are reasonable to be used. You must imitate what you see done by men of repute, and use the best common sense you can. I can tell you some things that you must not do. You must not go to work as if you were resolvd to reduce the hernia *per fas aut nefas;* you are not to spend an hour or even half an hour about it, or use all your force, or take off your coat and turn up your shirt-sleeves, or kneel on the bed, that you may press with the more weight; you are not to let half a dozen persons try their hands in turn. You are not to do these or the like things, all of which I have known as the sources of dire calamities. You are to be gentle and self-restraining, mindful of the delicacy of some of the structures you are handling, and that you may do them much more harm than would come of the operation which you are trying to avert. These cautions are the more necessary because, when the patient is under chloroform, you have nothing but your own sense and senses to tell you how far you may go without doing harm. The great value of chloroform and ether is that, by abolishing sensation, they put an end to the muscular resistance to reduction which, whether he will or no, the patient makes when hurt by the pressure of his hernia. Hence they are useful in herniæ, in most of which the difficulty of reduction is chiefly due to muscular resistance; in the recent, or in the recently much enlarged; in the inguinal more than in the femoral, and in these more than in the umbilical; in the painful more than in the painless. Chloroform and ether are by so much the most potent helps to the reduction of herniæ, that it may seem as if it would be right to use one of them without waiting for the influence of a warm bath, or recumbency, or any similar means. Sometimes it is right thus to do, especially in herniæ that have only very recently come down and are intensely painful. But more commonly, if there would be danger in waiting for three or four hours, it is because strangulation is so far advanced that the operation ought to be done at once, without any previous attempts at reduction. If there be no such extreme urgency for immediate reduction, there can be nothing but advantage in the use of the bath and the three or four hours' rest in bed; for they may make the hernia reducible, or, even if they fail of this, they may cause changes in it which are beneficial for both the performance of the operation and for the probabilities of recovery after it.

I have been speaking lately of the plans for average or medium cases; and before, of the cases in which no attempt at reduction without operation should be made.

You may ask, Are there any cases in which it is justifiable to wait longer after the warm bath, and rest, and chloroform, and a fair attempt at reduction, have been tried and have failed? I will not venture to say that such a case for waiting cannot happen; but I am clear that your rule, with barely an exception, must be that, when you are satisfied that a hernia is strangulated, and you have failed to reduce it with such helps as I have indicated, you should operate. While the patient is still under chloroform, the operation should be done; and you should prepare for it before giving chloroform. Of course, if you are satisfied that the hernia, though irreducible, is not strangulated, you may wait; but in this case you must watch almost impatiently, for an intestine or omentum that cannot be reduced is very likely soon to become strangulated, and so is one that is inflamed or blocked up in a hernial sac. Still, if no signs of strangulation, especially if no vomiting, should supervene, you may wait from day to day; but if the signs do occur, especially if there arise vomiting, or increase of pain, or increasing rapidity of pulse and breathing, then you must operate at once, and you had better not try again at reduction. The trial is much more likely to do harm than to do good: you had better operate at once. Nothing does more harm to a strangulated or nearly strangulated hernia than the force of an unsuccessful attempt at reduction.

While you are waiting, you may use, in different cases, ice or warm dressings, enemata, aperients, or opiates. I cannot tell you the indications for each of them. I am glad to have had no sufficient experience of waiting to have weighed the several values of these things; glad because I have no doubt that, for every case in which an operation has been avoided by waiting, there have been two cases in which lives have been lost by waiting too long. But there are at least one or two conditions favourable for all cases in which you desire to wait; namely, rest in bed and very sparing food. Nothing should be allowed to disturb the patient's rest, and no handling of the hernia should be permitted. Part of the value of ice and poultices and other like applications is this, that they all keep hands off.

Of other supposed helps I will not speak—of tobacco, and curious postures, and shakings with the legs up and the head down, and cupping-glasses, and other like and unlike things. They are ingenious wrong-doings, more dangerous than the operation which they are intended to avert.

In speaking of herniæ as being reducible, I have had in mind only such as can be completely and certainly reduced. But it is not uncommon to meet with cases of strangulated hernia, in which the reduction is doubtful or partial. As I looked through my cases, I found many of these recorded, in which there was delay in sending patients to the hospital, because surgeons believed that part of the hernia was put back, and hoped that the rest would soon go; and some in which, even in the hospital, there was mischievous delay through the same fallacious hope. It is not easy to say what takes place in these partial or doubtful reductions. Some patients will tell you that the whole never did go back, and that what now seemed to be reduced might only be an additional protrusion. Sometimes, I think, air is pushed back from the intestine, or fluid from the sac; sometimes omentum is put back; sometimes, perhaps, part of the intestine; sometimes nothing—the whole notion of reduction being fallacious. The liability to deception is greater than you would imagine. You may feel a thrill of receding fluid, or a gurgling of air, which you may suppose to be what some describe as the characteristic gurgling (as if anything of the kind were infallibly characteristic), or something slipping back; but all may be fallacious. There is one practical rule for all these cases. If the symptoms of strangulation be not relieved by the supposed reduction; if the vomiting continue, or the pain, or the patient's sense of distress, or any other of the distinctive symptoms, then, without delay, you must operate. A partial reduction of a strangulated hernia, if it be not followed by a complete relief of symptoms, is in nothing better than no reduction.

I may add, that most doubtful reductions are not reductions; and of the partial reductions, none are safe except some of those in which intestine is put back and only omentum remains in the sac.

Be prepared also for cases in which reduction is, or seems, complete, and yet the signs of strangulation are not relieved. In these, a hernia may be returned *en masse*, or pushed into another sac, or between the peritoneum and fascia; or the case may be one of hernia complicated with an internal strangulation, or one of many other conditions so hard to discriminate and deal with, that I can give only one general rule for their management—viz., that if you can feel a lump at or near the hernial ring, as if there were something which may be a strangulated hernia, then you must operate.

To end what I should say respecting the propriety of operating, I ought perhaps to speak of the condition of the patient as affecting the risk of the operation by reason of age and general health and various complications. Among my cases, I find not only many of the fattest and feeblest, but examples of complication with phthisis, acute and chronic bronchitis, aortic constriction, phlebitis, gastric ulcer, diseased bladder, intestinal disorders of various kinds, and internal strangulation. Patients such as these were one would not wound for any trivial good; but, with a strangulated hernia, the peril of doing the operation can hardly ever be so great as the peril of leaving it undone. Old age and feebleness, fatness, intemperance, or unsoundness of whatever kind, may add to the risks of this, as of any other operation; but all these risks must be accepted. A patient must not be allowed to die with a strangulated hernia, if by any means whatever the strangulation can be relieved; and you must not be averted from the operation by any consideration of the number of deaths that follow it. The deaths after the operation may be 50 per cent.; but the deaths due to the operation are not more than 2 or 3 per cent., and even these would probably have been deaths from the hernia if the operation had not been performed. The great proportion of deaths is made up of those in whom the strangulation has done mischief which the operation cannot remedy. It is not unfair to maintain that, speaking generally, the deaths after operations for hernia are only to be counted as failures to save life, while the recoveries are to be counted as lives saved from certainly impending death.—*Brit. Med. J.*

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Clinical Lecture on Tracheotomy in Cases of Laryngeal Disease.—By Ebin. Watson, M.D., Prof. Phys. in Anderson Univ., and Surg. to the Royal Infirmary, Glasgow.

Gentlemen: Chronic disease of the larynx is of many kinds and varieties, and of these you have lately had some illustrations in my clinical wards. Most of these cases get better, if properly treated, without operation; but for this end the patient must be perhaps confined to the house, and certainly retained for a long time under medical care. Hence it is likely that a certain proportion of such cases will become worse from various causes, not quite under the control of either doctor or patient. Again, there is a peculiar danger incurred by this class of patients which can never be wholly obviated—namely, the tendency to acute exacerbations of their disease. This tendency, while in a degree common to all chronic diseases, is peculiarly remarkable in the chronic affections of the larynx, and thus the patient may at any time be brought into imminent peril requiring surgical interference.

These remarks have been dictated by two cases which we have just been watching with much interest—the one to an unexpectedly fatal termination, the other to a more favourable issue. I wish now to call your attention to the chief features of these cases, and the more important clinical points connected with the operation performed in both of them.

The first case was that of a man, aged forty-three, recommended to me by a medical gentleman in the country. I saw him in private some time before his admission to the hospital, and prescribed for him; but, as he became worse, he returned to town, by my advice, to have tracheotomy performed. The case was one of long-continued chronic laryngitis

ending in ulceration of the glottis and necrosis of the right border of the thyroid cartilage. There was also some œdema of the aryteno-epiglottidean folds. I showed some of you these lesions by means of the laryngoscope before operating, for they could thus be quite clearly diagnosed. The stethoscope, however, gave very unsatisfactory evidence of the state of parts because of the great noise produced in breathing; but it was evident that the glottis never yielded sufficiently, and that very little air was admitted to the lungs. Yet the percussion was good over the greater part of the chest, and the man's general health was reported to be fair.

I therefore determined to open the trachea as the obstruction to the breathing was at the glottis, and could not be, at this stage of the case, relieved within a considerable period of time. To enable the man to breathe during the period of treatment was thus the primary object of the operation. But it had also another object—viz., to give the parts complete rest. For as in ordinary breathing the glottis is constantly moving, so still more is it agitated in forced or difficult respiration. Hence the continual aggravation of the ulcers on its surface and the frequent excitement of œdema in its neighborhood.

In approaching the operation of tracheotomy you have first to consider the question of giving chloroform. Now, in the case before us the anæsthetic seemed to act very badly. The man fainted and ceased to breathe, and the operation was performed on him while in a state of apparent death, from which he was only rescued by artificial respiration performed through the tubes. The same thing has happened three times in my experience, and it is very alarming; though I am happy to be able to add that all three cases rallied and recovered. It is very strange that two of them occurred to me in this hospital and during the present session, within a few weeks of each other. Other surgeons have met with the same difficulty more or less frequently, and it becomes us very seriously to consider the cause or causes of the occurrence referred to, and whether or not it should prevent us from employing chloroform during tracheotomy.

I remark here, then, that in some, perhaps in many, of these cases the cause of the syncope is neither entirely due to the chloroform nor to the laryngeal disease. And this is proved by the case under discussion; for, when the patient died, a fortnight after the operation, it was discovered that the surfaces of the pericardium were completely adherent. Now you will remember that the man fainted before he became insensible with the chloroform, and that while in the hospital he had another similar faint without chloroform; and, indeed, I believe he died in a third attack, which might not have been fatal had it not happened during the night —for he was found dead in bed. He had not been so well as on the day before: he had been out of bed for the most part of it, and was cheerful and happy. The faints, and finally his death, were caused by the heart disease; and I believe the faint at the time of the operation was but doubtfully connected with the chloroform. Any agitation or excitement might have produced it, or it might have occurred, as the fatal seizure did, without any cause appreciable by us. And so likewise may it be in other cases. I do not mean that adherent pericardium can reasonably be supposed to exist in any considerable number of them; but I do think it not unlikely that causes quite apart from the action of chloroform, or the conditions demanding operative interference, often occasion the difficulty to which I now refer, and that, as most cases recover, these causes are never definitely discovered. I have, indeed, been sometimes tempted to explain this occurrence as caused by the retention of more than the usual quantity of chloroform in the lungs, owing to the partial failure of the expiratory efforts under the anæsthetic influence, combined with the obstruction of the larynx. This is especially likely in cases of so-called œdema glottidis, in which, when the muscles of the tongue are paralyzed, the œdematous folds at its root and at the sides of the epiglottis are allowed to fall down upon and to fill up the glottis. In this

way a more abundant and rapid absorption of the chloroform would be caused, and it might thus affect the heart so as to produce syncope. Of course it may be said that in every administration of chloroform there is some risk of a similar misadventure; but it is undeniably more frequent in cases requiring tracheotomy than in others. Fortunately, however, it is not, after all, very common; for, out of a considerable number of cases, I have only met with it three times; and I think it need never end fatally if you attend to the precautions I am about to mention to you.

In the first place, be on the watch for its occurrence, and be prepared to combat it. Never, if possible, attempt such an operation without at least one reliable surgical assistant being present to help you. In the next place, be not easily dismayed, and do not for a moment think of desisting from opening the windpipe; on the contrary, proceed, as rapidly as may be, with the operation: introduce the tube and make artificial respiration, taking care that in doing so the tube is not jerked out of the trachea. I beg you not to neglect the practice which you saw me pursue—namely, to pull forward and to jerk the tongue frequently during the period of returning animation. Of course this is not done to admit air to the windpipe, for we suppose that the tube is fairly in the trachea; but I believe it acts as a powerful stimulus to the pharyngeal branches of the pneumogastric nerve, which you know is the chief exciter of respiration. Lastly, persevere long in your efforts at restoration, and, as soon as possible, administer a little brandy-and-water. In one of my three cases it was fully a quarter of an hour before the above-mentioned proceedings could be safely desisted from.

The second of the two cases of tracheotomy which you have seen with me this session was likewise sent to me from the country, and was an example of an acute exacerbation of long-continued laryngeal disease. There were no ulcers visible in this case even on careful examination with the laryngoscope, but only very abundant œdema of the aryteno-epiglottidean folds. Some of you will remember that a year ago this patient was treated by me in Ward 26 for the very same state. The means then used were, free incision of the œdematous masses by means of the laryngeal lancet, and the administration of the iodide of potassium, with the application of iodide liniment over the larynx externally. She at that time recovered; but the present attack was more severe, and, taking into consideration the condition of the glottis beneath the œdema, I recommended tracheotomy as a measure indispensably necessary in order to a more thorough treatment of the larynx.

Now, in your surgical text-books there is a good deal written about the choice of the part of the trachea to be opened in such cases—namely, whether it should be above or below the isthmus of the thyroid body. I do not, however, think that this is much attended to, or much deserving of attention, in practice. I believe that the isthmus is often cut through with perfect impunity, and I am sure that it is seldom seen in the performance of the operation. The great rule which I would impress upon you is, after cutting through the skin and superficial fascia (which you ought to do exactly in the median line), to use the edge of the knife as little as possible. Take the back of its point, or even its handle, and thus separate the muscles in front of the trachea, so as to avoid wounding the vessels; and, it, after doing this, you perceive the isthmus, push it up with the blunt end of the scalpel and clear the tracheal rings below it. You may then plunge in a small sharp hook to steady the trachea, and open it the necessary extent to admit the tube. In a few cases you may find the veins very turgid; and they sometimes are torn or cut, and bleed abundantly. It is now pretty well established as a rule in surgery that you ought not to wait for the complete subsidence of this venous hemorrhage before opening the trachea. Yet it is better to do so if you can, and if there is no very urgent call for haste. You will, in such cases, find acupressure needles very useful, for they may be made to include and restrain bleeding from the entire lip of the wound.

The only other point to which I think it necessary at present to refer is the length of time which a patient may require to wear the tube in the trachea. Now this varies greatly—in my own experience, from a few days to several years. Only a few days ago I withdrew a tracheatube from a boy's throat four years after I had introduced it for him. At the time of the operation his case was very similar to the one on which I have just been commenting, being an acute exacerbation of a chronic laryngitis. I saw him with Dr. James Stewart, whose patient he was, and by whom he had been carefully treated for a long time previously. Soon after the operation he became strong and active. He attended school, and latterly, with his father's family, resided out of town. When he was brought to me the other day, I found the tube quite filled with the granulations, and the boy had a very fair voice, which was improved on withdrawing the tube. I had some difficulty in persuading the parents to allow the wound to heal, but I am sure the tube was no longer necessary.[1]

Other examples of retention of the tube in the trachea for periods nearly as long as in the case just mentioned have come within the range of my own observation, and I never knew any bad results from this cause. Notwithstanding, therefore, a contrary experience in a few exceptional cases, I believe you need not fear to retain a properly made silver tube in the windpipe, even for years, if it is required so long.

The patient on whom I last operated will in all probability require to wear the tube for a long time, because of the nature and previous continuance of her disease; in fact, she must wear it until other measures have had time to effect a cure and enable her to breathe freely though the glottis. The progress of the case will be from time to time ascertained by means of the laryngoscope, which is quite invaluable for all purposes of diagnosis in the larynx, and the use of which is quite indispensable to the right treatment of its diseases. But I cannot in this lecture enter upon the various remedies appropriate to such a case as that before us; I may, however, mention that these must be both local and constitutional, having for their object the complete removal of the œdema and the restoration of the indurated valve of the glottis to its natural mobility. The laryngeal lancet and various kinds of inhalations from the spray apparatus should be first employed, and afterwards the topical application of solutions of nitrate of silver, of different strengths, according to the state of the parts. The chief internal remedy on which I rely in such a case is the iodide of potassium; and sometimes I prescribe a short course of the iodide of mercury, taken at the same time with the other drug. By such means I hope that our patient will in due time be restored to perfect health.—*Lancet*, Aug. 30, 1872.

[1] The wound soon closed up, and the boy remains well.

HOSPITAL NOTES AND GLEANINGS.

On the Use of Plaster Splints in Remedying Displacements in Fractures Irreducible by Other Means.—All surgeons know how difficult it is sometimes to remedy certain cases of oblique fracture of the lower third of the leg, in which the upper fragment projects under the surface. Various apparatus have accordingly been devised for the purpose of preventing this displacement. In France, Malgaigne in such cases used to employ his metallic point, which was fixed into the upper fragment so as to exert a certain degree of pressure, and prevent any fresh displacement. The fixing of the metallic point was attended with some inconvenience; besides, it is a special instrument and not easily procurable. We were therefore struck with the advantages afforded by an ingenious contrivance which we saw Dr. Labbé employ with success a short time ago in his wards at the Hôpital la Pitié.

The patient was a woman aged forty. Whilst in a state of intoxication she had been run over by a gig, and was at once conveyed to the hospital. Fracture of the lower third of the leg was found to have occurred, with very marked displacement of the upper fragment, which projected

under the skin and threatened to tear through. A splint was immediately applied by one of the house-surgeons.

As the woman was labouring under delirium tremens, it was found necessary to use the strait-waistcoat, and strong doses of opium were administered. However, in consequence of the restlessness of the patient, the upper fragment of the tibia projected more and more under the skin, so that it became necessary to use some means to prevent its issue through the surface. Accordingly the apparatus was modified, and a cushion placed under the heel, but to no effect, and there was imminent danger of the fragment lacerating the skin. It was at this time that Dr. Labbé first saw the case, and with the view of definitely remedying the displacement and preventing deformity, he applied a plaster splint in the following manner: Reduction was first performed with the greatest care. As soon as this was completely effected the plaster splint was applied so as to cover the sole of the foot, the heel, and the whole of the posterior surface of the leg. The assistants were then requested to continue extension, counter-extension, and perfect apposition of the fragments, until the plaster had become hard. At the end of half an hour the apparatus was sufficiently solid. From that moment all anxiety about a breach of surface ceased, and, notwithstanding the disorderly movements of the patient, which continued two days longer, consolidation took place so perfectly that it was quite impossible to make out the seat of the fracture.—*Lancet*, Aug. 3, 1872.

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Cases under the Care of Sir Henry Thompson *at University College Hospital:*—

Pain after the Use of the Lithotrite.—Persistent pain after a series of crushings may be due either to soreness of the vesical mucous membrane or to the irritating presence of a remaining fragment. Sir Henry Thompson pointed out, in reference to the following case, that it is important in any given instance to ascertain, once for all, which of these conditions exists; inasmuch as a fragment, if there be one, must be removed without delay; while, if the pain arise from soreness of the mucous membrane, every additional introduction of an instrument is calculated to increase the mischief. Inquiry should be made as to the frequency with which the patient micturates, and as to the occurrence of pain after micturition, and its situation. If any doubt remain, a final and careful instrumental examination should be made; and for this purpose it is desirable that the bladder should not contain much urine. In the case in point the patient had undergone five crushings for the removal of a uric acid stone; he complained of persistent pain in the bladder, with pain in the glands at the end of micturition. Having made a general examination of the interior of the bladder with a sound, Sir Henry Thompson introduced a lithotrite, and, having depressed the handle, carefully explored the region behind the prostate with the slightly separated blades turned downwards. These came into contact with no solid substance, and were brough together without any sense of resistance. On the withdrawal of the lithotrite a very small quantity of powdery matter was found between them. The patient was directed to take a mixture containing liquor potassæ and tincture of henbane, each in the proportion of half a drachm to the dose, and to use a hot hip-bath; and, as a specimen of his urine presented a light deposit consisting chiefly of mucus, the house-surgeon was requested to ascertain whether the bladder was completely emptied by the natural effort.

Painful Ulcer following Ligature of Internal Piles.—Another patient had undergone ligature of some internal piles, and had passed the usual period of convalescence. He complained, however, that the passage of every motion gave rise to agonizing pain at the fundament, and to a long-continued heavy pain in the lower lumbar region. On examination there was found at the spot where one of the ligatures had come away a rough ulcerated surface. So painful was it, that pressure on the corresponding surface of the buttock, about an inch and a half from the anus, could scarcely be

borne. An incision was made through the ulcer as for fissure of the anus.

Urethral Fever.—There occur from time to time cases in which the passage of an instrument into the bladder is followed by exceptionally severe constitutional symptoms. One remarkable case of the kind was lately under Sir Henry Thompson's care. The patient was admitted with a urethral stricture which was first overcome with a small instrument which was tied in the bladder. During the succeeding fourteen days, instruments of gradually increasing size were introduced and tied in; the urethra having then recovered its normal dimensions, Sir Henry undertook to teach the patient to pass a catheter for himself prior to his discharge. He gave the first lesson by himself guiding the patient's hand. Rigors, vomiting, and severe febrile symptoms followed this procedure; the urine became tainted with pus, the intelligence clouded, and the patient's look fixed and stolid; he could keep nothing on his stomach but a little milk and soda-water. When we saw him on the fourteenth day after the occurrence of this complication, his symptoms indicated only a very slight improvement. In speaking of this and other less severe cases, Sir Henry first drew attention to the absolute immunity from similar complications which is enjoyed by women. He pointed out that the male urethra is some six inches longer than that of the female, and attributed to that additional extent of surface the greater irritability and liability to a special form of constitutional disturbance which men display in an affection which always presents three stages: cold, dry heat, and moist heat. Frequent examples are afforded of patients who undergo the introduction of an instrument with apparent impunity, but on their way home a chill is felt, which, with the succeeding symptoms, are attributed to a cold. This complication, Sir Henry said, occurs in various degrees of severity, but seldom does it happen to be so severe as to endanger life, as in the case under observation.

Operation for Recto-vesical Fistula.—To another patient the galvanic cautery was applied to a recto-vesical fistula which had followed an operation for stone performed fourteen years ago. The cautery is applied periodically, and each time its use is followed by improvement. Before the last operation, the patient passed water by the natural passage, but a small quantity escaped into the rectum when he walked.

In the Out-patient Department we saw one or two cases of chronic orchitis and painful enlargement of the epididymis, following gonorrhœa; the patients were directed to keep the scrotum enveloped in a piece of lint covered with an ointment of the following composition:—Half a drachm each of strong mercurial ointment and iodide of potassium ointment to two ounces of simple ointment. Sir Henry advised them to further dilute the preparation with lard, if they should suffer inconvenience from its use. Special injunctions were also given that the part should be well suspended by means of a handkerchief attached before and behind to a girdle of some kind.—*Lancet*, Aug. 31, 1872.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Fever by Withdrawal of Heat.—By F. Peyre Porcher, M.D., Prof. of Clinical Medicine in the Medical College of the State of South Carolina.

The article on hyperpyrexia treated by withdrawal of heat, published in the No. of this journal for August last, page 128, brief as it is, is, I think, highly important, as it embodies the method and expresses concisely the principles upon which many of us have heretofore treated and will treat several classes of disease, viz., by the mere *physical abstraction of heat.* If this process is not by itself curative, it tends materially to assist in the cure of several diseased conditions which are accompanied by high temperature.

I invite attention to it on account of its intrinsic merits, and because in the section of my paper in the *Transactions of the S. C. Medical Association*, 1871, on Yellow Fever, in the more detailed sketch of the

treatment of the disease in the *Proceedings* of the same association for 1872 just printed, in papers published in the *Charleston Medical Journal* as long ago as March, 1859, and in a communication on "Gastric Remittent Fever," I laid special stress upon the importance of *the reduction of temperature* in their management. It is indifferent whether this is accomplished by the use of purgatives, mercurial or saline, by quinia, or by the application of cold water, severally or conjointly.

The combustion and consequent destructive tissue changes in some fevers have their origin in gastro-intestinal, hepatic, or other inflammations or irritations of mucous membrane, as in gastro-enteric remittent, in typhoid fever, in hepatitis, etc. Even in these, as well as in others in which there are also real organic lesions, the reduction of temperature by the several means used is beneficial. In yellow fever the force of the disease, the poisoning which gives rise to it, is not seated, I believe, in these tissues or organs, but rather *in the blood* itself. Hence in this disease reduction of temperature has a peculiarly important influence for good. Ice cold water, with other agents, if assiduously and efficiently applied, in time, has much to do with keeping down the high temperature, lessening the combustion, contracting capillaries, arresting tissue changes, and preventing all the dangerous symptoms, such as irritability of the stomach, black vomit, engorgement of the kidneys, albuminuria and arrest of the urinary secretion, coma, and convulsions, which are owing to the altered condition of the blood caused by the high temperature attendant upon excessive fever. I had said (in one of the articles referred to) that "the danger arises from the persistence of a fever of too great intensity, accompanied with a high combustion, and which, if unchecked, leads to all the fatal consequences—to coma, to delirium, to decomposition of blood, to black vomit, hemorrhages, etc. Arrest or diminish the fever and you prevent all these results."

So that in the reduction of "hyperpyrexia" we have a special and separate means, worthy the attention of all physicians, for the arrest and cure of certain morbid states. The same applies in explanation of the use of cold water and irrigation in surgical cases. The method and the application of the means recommended are quite old and have been long used; I only take this occasion to encourage a more systematic resort to them for the reasons given.

The channels in which certain forms of treatment run are often suddenly and greatly deepened by occasionally formularizing and enforcing the reasons for which they have been constructed and used. To do this in the present instance would, I think, be attended with great benefit to physicians and to mankind.

I believe that baths, partial or complete, are useful; but that the most practical and efficient mode of reducing temperature, because more easy of application, is by the assiduous use of cloths dipped in ice cold water applied for from fifteen to twenty minutes to the head and to the palms of the hands, discontinued and repeated at appropriate intervals. This, with the other agencies referred to above, will reduce the intensity and keep in subjection almost any form of fever, as I have observed from repeated experiments.

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Rapid Death from Stings of Bees.—By J. O. Sanders, M.D., of Carrollton, Mississippi.

April 18th I was called to a plantation two miles distant to see a patient stung by bees. Mr. S., an intelligent man, gave the following account. Louis ——, a negro, aged about 45, climbed a tree where bees had swarmed on a limb, for the purpose of hiving them, carrying with him a saw. As soon as the limb commenced falling, the bees arose *en masse* and covered his head and face. He descended immediately, and, as soon as he reached the ground, commenced running as fast as he could; ran around three sides of a yard, some two hundred steps, passed through an open gate and fell to the ground. Mr. S. ran to him with a bottle of spts. camphor, and succeeded in forcing him to take one swallow, the patient protesting at the time against assistance, declaring that he

would certainly die. After two or three irregular and partial respirations he expired. Mr. S. thinks it could not have been more than five minutes from the time he was attacked by the bees before he breathed his last. When I arrived, about an hour and a quarter after the accident, I could, on careful examination, find no signs of life. He was a vigorous, muscular man, and in perfect health, so far as I can learn. Was death due, in this case, to direct nervous shock, or to absorption of virus, or both?

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Apparent Death.—Dr. W. H. Lathrop, Prof. of Diseases of the Brain and Mind in Detroit Medical College (*Detroit Review of Medicine and Pharmacy*), in his paper on "Apparent Death," reports one of the most remarkable and best authenticated cases of trance on record, that of William (afterwards Rev. Dr.) Tennent. While studying theology at Princeton, N. J., he had a fit of catalepsy, being in a very weak state from close application to books, without proper attention to physical exercise. After a short illness, he was regarded as dead, and the day was fixed for the funeral. His physician, however, believed him to be alive, and succeeded in having the funeral postponed from day to day for three days. The brother of Mr. Tennent then insisted that it was folly to suppose that he could be alive, and ordered that at a certain hour the burial service should occur. When the appointed time arrived, and the company were assembled, the doctor stood over his patient and asked for still another hour. At the end of that time the patient suddenly uttered a groan, and soon after gave other signs of life. His recovery was slow, and at first was attended with a loss of memory. He commenced anew the study of Latin with as much difficulty as if he had had no previous acquaintance with the language. After a considerable time his memory suddenly returned. This case is fully authenticated. The witnesses were educated persons, and all the particulars have been carefully described. Such cases, therefore, are *possible*, though extremely rare.

In conclusion, Dr. L. observes: 1st. That trance is extremely rare; 2d. That apparent life in those really dead is much more common; 3d. That in doubtful cases we should wait for the appearance of decomposition before allowing the burial to take place.

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Yearly Statistics of the New York Board of Health.—Dr. Chas. P. Russel, Chief of Records of Vital Statistics, in his annual report says: The death-rate for the year was 28.6 per 1000 of the population, a higher rate than can be found in any other city of importance throughout the States, with few exceptions. The total number of deaths caused by zymotic diseases during the year amounted to 8364. Smallpox carried off 805 persons. During 1871, 70 persons, 27 men and 43 women, died at an age exceeding 90 years. Of the total number of deaths, 1071 were due to accidents, 112 to burns and scalds, 15 to kerosene explosions (all women or young girls), 187 to drowning, 395 to fractures, 45 to suffocation, 14 to accidental poisoning, 82 to the Westfield disaster, 93 to steam and street railroad cars, 54 to the July riot, of whom 27 were Irish, 15 Americans, 4 Germans, 3 English, 1 Scotch, 1 Australian and 1 Canadian.—There were 65 murders during the year, but only one murderer, a coloured man, was hanged. There were 114 suicides, of whom the greater part were Germans.—*Medical Record*, Aug. 1, 1872.

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Condurango. — The newspapers announce the death from *cancer*, on the 11th of August last, at South Bend, Indiana, of Mrs. Mathews, the mother of Vice-President Colfax, whose cure by condurango was so triumphantly announced some time since. The result of this case is a sufficient commentary on the value of this greatly vaunted remedy, and will put an end, we trust, to the disgraceful commercial speculation in this drug.

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Health Resorts at the South.—The *Boston Medical and Surgical Journal* for July 11 last, contains an interesting article on this subject by Dr. Wm. W. Morland. The author speaks very favourably of Montmorenci, about four miles from Ai-

ken, S. C., which he regards as a most admirable site for a *sanitarium*.

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Mortality in Philadelphia.—The mortality in Philadelphia is reduced to nearly the ordinary average. The number of deaths during the week ending Sept. 21 was 277, of which 13 were from cholera infantum, and 1 from smallpox. The epidemic of the latter may now be considered as having ceased.

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Medical College of the State of South Carolina.—In the announcement of the session of 1872–73, it is stated that the forty-fourth course of lectures in this institution will commence on the 15th of October and terminate on the 15th of March, thus extending the term one month. This is a step in the right direction, though it does not go far enough, and shows that the public sentiment of the profession is having its influence with the medical schools. The present advanced state of our science and the new field opened for cultivation demand not only a lengthening of the courses of instruction, but also greater facilities for clinical instruction, the appointment of teachers on special subjects, and the institution of laboratories affording conveniences for experimental investigations. To assert that our present system of education is entirely sufficient because some few educated by it have arrived at distinction, is as absurd as to maintain that all education is needless, inasmuch as Hugh Miller, a wholly uneducated laborer in a quarry, attained to high scientific eminence.

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Obituary Notices.—Died in this city, on the 19th of August, at the mature age of 77 years, Dr. John Bell. Dr. B. is well known as a voluminous contributor to medical literature. He is the author of a work on "Baths and Mineral Waters," which has gone through several editions; he edited, with additions, "Stokes' Lectures on the Practice of Physic," "Combe's Treatise on the Physical and Moral Management of Infancy," etc. etc., and contributed very many papers to different periodicals and reports to societies. He lectured for several years in the Philadelphia Medical Institute, and occupied for one session the chair of Theory and Practice of Medicine in the Ohio Medical College. For several years his health had been declining, and incapacitated him from active professional duties.

—— August 15, 1872, in the 62d year of his age, Mifflin Wistar, M.D. Dr. W. was a son of the late eminent professor of anatomy in the University of Pennsylvania, and though he received a thorough medical education, and doubtless would have achieved great professional distinction, yet having inherited a competency he never engaged in practice. He was a high-minded, honourable, refined and modest gentleman, who, though not much known in public life, was greatly endeared to a select circle of friends by his generosity, unselfishness, and thoughtful consideration for the welfare of others.

FOREIGN INTELLIGENCE.

Hypodermic Injections of Quinia.—The salts of quinia, and especially the hydrochlorate, says Dr. Otto, are not sufficiently soluble to be commonly employed in subcutaneous injections, and the surgeon can neither be sure of the dose required, nor of the rapidity of their action. He recommends the use of pure quinia dissolved in ether; this solution is much less irritating than either the acid or alcoholic solutions. Quinia dissolves in ether in sufficient quantity to produce a prompt action, and to permit a considerable dose to be injected. The quinia should be dissolved in the ether, which should then be filtered and allowed to evaporate to some extent, so that a more concentrated solution may be obtained. The solution he uses contains, in about half a drachm, five grains of sulphate of quinia. Dr. Otto has never observed any local inflammation caused by the injection of this solution, and he has injected as much as five grains of the quinia at one time without finding any other inconveniences than those which ordinarily accompany large doses of quinia, such as buzzing in the ears. The injection of this quantity

rapidly produces a depression of the temperature of the body amounting to 1° C. Hypodermic injections of quinia are particularly suitable to cases of puerperal fever, and those of purulent infection; but they may also be employed with advantage in cases of intermittent fever.—*Practitioner*, Sept. 1872, from *Le Mouvement Médical*, June, 1872.

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Rapid Control of Epistaxis.—Dr. Marin, of Geneva, considering that in this accident the blood comes usually from one nostril only, and mostly from the anterior third of the latter, has tried to compress the facial artery on the superior maxillary bone, close to the ala nasi. The efflux of blood into the cavities of the nose is thus stemmed, and the epistaxis soon stops. M. Marin says that he has thus relieved many persons in the street, on board steamboats, in railroad carriages, and even at the theatre.—*Lancet*, July 20, 1872.

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Treatment of Snake-bite by the Injection of Ammonia.—Mr. T. H. Webb, resident surgeon of the Creswick Hospital, writes to the *Australian Medical Journal* touching the treatment of snake-bite by the injection of ammonia into the veins, and he makes the following startling remarks on the careless use of the hypodermic syringe: "The enormous ulcers this caustic creates, the way it burrows, destroying the cellular tissue wherever it touches it, is something incredible. Twice in as many years have I had to ligature the brachial, above and below, for sloughing into the artery, and in both cases have the patients nearly lost their arms from gangrene, and their lives from hemorrhage." He gives the case of a man who had been "hypodermically injected with ammonia; as might naturally be expected, wherever the caustic has entered, an ulcer remains. And such ulcers! One could almost pursue a course of muscular anatomy on his feet, legs, and thighs, whilst at the bend of the elbow the deepness and extent of the slough have compelled him to constrict his brachial. He may well say, 'The evils that it hath pleased Heaven to affect me with I could have borne, but the evils *plus* their remedies—impossible.'" "I declare most emphatically," continues Mr. Webb, "that, instead of the venous injection being a little operation, which anyone can on an emergency perform, it is one that none but a surgeon should attempt, and yet I have several times seen hypodermic syringes in the possession of laymen, kept for the purpose, though how they were going to use them Heaven only knows."—*Lancet*, Aug. 24, 1872.

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Tracheotomy.—M. E. Dudon, of the Hôpital St. André, Bordeaux, has just published the account of twelve cases of tracheotomy which he performed, and in six of which cure was effected. From the careful study of his twelve cases M. Dudon draws a moral which has so often been pointed out, especially by French surgeons, but which cannot be too often repeated—namely, the necessity of not waiting too long before opening. M. Dudon is convinced that had he been able to operate sooner, some of the unsuccessful cases would have ended favourably. The less the false membranes have extended to the trachea and bronchi the better respiration is restored; the less asphyxia is marked and the blood altered, the more the strength of the child will be preserved to resist the disease. "Considering," says the author, "trachetomy to be in itself a benign operation, when viewed independently of the morbid causes which may necessitate it; convinced that if regularly performed upon healthy children it would scarcely ever occasion death; persuaded, as I am, that it is advantageous for children affected with croup to be operated on at an early stage of the disease, before the malady and asphyxia have made any great progress; and backed by the results of my twelve cases, I believe I am justified in saying that tracheotomy is an operation which, to produce all the good results which are expected from it, must be practised early—I mean as soon as the larynx is invaded by the false membranes and medical means have failed. It may well be compared with the operation for strangulated hernia, which, when performed at the beginning of strangulation, after taxis under the influence of chloroform has proved

unsuccessful, affords much more favourable results than when ulceration or gangrene of the intestine and the development of peritonitis have been allowed to take place."—*Lancet*, July 20, 1872.

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Thoracentesis in Infantile Pleurisy.—In the course of the discussion still going on at the Paris Academy of Medicine on empyema, Dr. Roger, physician to the Hôpital des Enfants, had occasion to relate the results of his vast personal experience of empyema in children. Referring especially to the question of thoracentesis, and basing his opinion upon a great number of facts which he related, Dr. Roger thus tersely summed up his conclusions: Operate *always* in cases of *purulent* pleurisy in children; operate *rarely* in cases of abundant serous effusions; *never* operate in cases of slight effusion.—*Lancet*, Aug. 10, 1872, from *Bull. de l'Acad. de Méd.*

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Skin Grafts.—M. Ollier, of Lyons, considers that the connective tissue, and not the epidermis, is the active agent in the graft, and objects to sowing a number of small epidermic grafts. He cuts them from six to eight centimetres in length, and they succeed very well; but it is inconvenient to procure such large grafts. He freezes the skin before cutting it away, and finds that it still answers well, notwithstanding this assault upon its vitality. This is a veritable autoplasty, and the healed surface has a more persistent vitality than ordinary cicatrices.—*Brit. Med. Journ.*, April 27, 1872.

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M. Ollier's Occlusive Dressing.—In the last two numbers of the *Lyon Médical*, M. Poncet brings forward some new illustrations of the great advantage attending the employment of M. Alphonse Guérin's mode of dressing wounds with cotton, and associated, as recommended by M. Ollier (*Medical Times and Gazette*, May 11, p. 547), with the silicate bandage, so as to constitute what the latter surgeon terms *occlusion inamovible*. The object of these papers is, however, not to set forth the general advantages of this plan, which have now been made pretty widely known, but to show its great utility in warding off those hospital complications which have so often excited terrible effects—pyæmia, erysipelas, and hospital gangrene. During the last *semester* more than 100 of the *bandages ouatés-silicatés* have been applied in M. Ollier's ward (containing 100 patients) to every wounded surface, and not one of these patients has succumbed to pyæmia or been attacked by erysipelas. The bandage in these cases has been kept on for a week or fortnight, and sometimes three or more weeks; all accidents from such retention being guarded against by paying attention to the pulse, temperature and feelings of the patients. The bandage has had to be removed wholly or in part in a few cases, on account of the imperfect way in which it had been applied. In all cases, wherever possible, such removal has not been performed in the ward where the other patients were; the wound being also kept exposed for the shortest possible time; and the quite new, fine cotton taken only from the parcel as wanted. The portion of this brought in immediate contact with the wound has usually been impregnated with carbolic acid or alcohol. In this mode of dressing the minutest details must be observed, and the great object of exclusion of air can only be attained by the superposition of several thick layers of cotton, which must reach very far beyond the surface of the wound. Thus, after an amputation of the leg, it does not suffice to cover the stump with the silicated bandage, but this must also comprise the thigh and the trunk. Without such precautions it becomes a bad mode of dressing, retaining pus which has undergone change from action of the air in contact with the wound. Before the bandage is applied, as many arteries as possible should be secured, and for this purpose the wound should be left exposed for fifteen or twenty minutes.

M. Poncet gives various details concerning the chief classes of wounds which were treated during this period; and he observes that, if these cases were to be taken as conclusive, this procedure might be pronounced as an absolute preservative against these complications. No cases of pyæmia, erysipelas, or hospital

gangrene were observed in cases so protected, although the last two affections prevailed in the ward. However, he wishes for no exaggeration upon the subject, and observes that, while failure will occur wherever the bandage is imperfectly applied, even when its adaptation is perfect we only place the wound in the very best condition for healing by preventing complications from without. Its healing, however, of course depends also upon other circumstances. It is a means especially adapted for hospital practice, and is not required in cases treated in localities where the air is not likely to be contaminated. The cases M. Poncet relates were also treated in winter; but in summer the dressing may have to be renewed every five or six, instead of every fifteen or twenty days.—*Med. Times and Gaz.*, Aug. 3, 1872.

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Protective Power of Vaccination.—The enemies of vaccination may ponder with advantage over the following facts and figures laid before the British Medical Association at its late meeting, by the Rev. Samuel Haughton, M.D., D.C.L. :—

"When I come to England, I am astonished to find intelligent persons in numbers who, for some reason, come forward publicly to oppose the process of vaccination. Some of these people express a strong doubt—an honest doubt—whether the mortality from smallpox is really as fearful as the doctors say. To get a proper basis of calculations as to the mortality from smallpox among unvaccinated persons, we must go back to the records of past generations in this and other countries; and we find this astonishing result, that from 60 to 70 in every 100 persons attacked by smallpox must die if not vaccinated. Some people have the idea that this is a bugaboo of the doctors, and that they need not necessarily die if not vaccinated. Of course it is impossible now to get the experience of an immense number of persons who have not been vaccinated, to give them the smallpox, and see how many would die. This experiment could not be easily carried out. Therefore I adopted another method. I took it for granted that the writers and records of the close of the last century were correct. The average which they gave was that 66 per cent. of every class—men, women, and children—must die if they had got the smallpox and were not vaccinated; whereas, of those who were attacked after being well vaccinated, the number of deaths was only 6.6 per cent. This reduction of the mortality from 66 to between 6 and 7 per cent. represents what vaccination has done. The value of vaccination is, therefore, established beyond the possibility of a doubt, and I think that this is a subject on which the medical profession should speak out. Should not Birmingham, with her literary men and newspapers, lead the public on this great question? I wrote to my friend Dr. Hayden, of the Mater Misericordiæ Hospital in Dublin, to send me the total number of smallpox cases treated there, and of the deaths; and I undertook, from these figures, to calculate the number of those who were vaccinated and those who were not. This forms a very simple problem in mathematics, of which I will not trouble you with more than the results attained. From the figures sent me I calculated, though I had never seen a patient, that 120 of the cases treated at the hospital had not been vaccinated. I wrote to tell Dr. Hayden this, and he wrote back to say that the number recorded as known to be unvaccinated was 119. Since I have come to Birmingham, Mr. Woolley has kindly placed at my disposal all the information he possessed, and I hereby beg to tender him my warmest thanks for his courtesy. Although Birmingham has suffered what I cannot but regard as a most contemptible epidemic, the facts are strikingly illustrative of what, to my mind, is the truth of the principle which I am placing before you. Since the 18th November, 1871, there have been 1911 cases of smallpox, of which 262 have died. I leave out the cases remaining under treatment. I calculated from those figures that 230 persons in Birmingham who had been attacked with the disease had never been vaccinated. I found in Mr. Woolley's returns that the certainly non-vaccinated were 209, while doubtful cases numbered 44. Well, it was fair in such

a case to split the difference and call it 22, and, as that suited my theory very well, I adopted it; and when I added them to the 209 it made 231, which was only one above my calculation. It is like the trick of a conjurer, walking into the town, asking the number of smallpox cases and deaths, never having seen the patients, and yet telling the people of the town how many were vaccinated and how many were not. Dr. Trench tells me that 1616 cases were treated in the Liverpool hospitals; the deaths were 375; from that I calculated that the non-vaccinated cases numbered 451. The number actually recorded as non-vaccinated was 432, being 19 less; but I am perfectly certain that to those should be added several of those properly set down in the reports as doubtful. This opens up a problem highly interesting to the profession of medicine. As the mathematician in his closet can direct the astronomer in what part of the heavens and when to look for certain planets, so the progress of science and medicine can tell with certainty when and where certain districts will be attacked with epidemics. The records of the fearful epidemics and the plagues of the middle ages have perished; the poor have perished with no man to regard them. Even the writings of Defoe may be searched in vain for any statistics of the great plague which would satisfy the demands of modern medical science. But, by examining into the records of our own times, we shall be able to read back the history of the epidemics of the past, the number and percentages of the mortality of those who suffered, who lie forgotten in their graves, and whose history no one has recorded."—*Brit. Med. Journ.*, Aug. 17, 1872.

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Feeding by the Rectum.—The feeding of patients by nutritive enemata in cases of stricture of the œsophagus or pylorus, or whenever the upper part of the digestive tube must be relieved of its functions, has hitherto been anything but a satisfactory proceeding. The ordinary fluid food which is generally used for that purpose is either not retained long enough in the rectum, or cannot be digested there for want of a digestive ferment. Even the proposal of Meissner, to use an artificially prepared meat-peptone, has not always been found practicable, and the long time necessary for its preparation makes it quite unsuitable for daily practice. A decided step in advance has recently been made by Dr. W. O. Leube, of Erlangen (*Deutsches Archiv für Klin. Medic.*, vol. x.). Starting from the idea that it would be best to let the digestive changes which must necessarily precede absorption go on in the rectum itself, with its equable temperature, he devised a mixture of food and digestive ferment which, he found, is easily retained in the rectum from twelve to thirty-six hours. The digestive ferment is the fresh pancreas of the ox or pig, which, finely minced, he mixed with scraped meat, rubbing them well together with a little warm water, so that the mass may be easily injected. The most suitable proportion is one part of pancreas to three of meat. Fat may be added, but its quantity ought not to exceed one-sixth of that of the meat. Before this food is injected, the rectum ought to be washed out with water. Dr. Leube mentions that the first enemata sometimes apparently remain undigested, but that this must not prevent their being continued. Generally the feces resulting when this food has been retained sufficiently long have the character of ordinary fecal matter. By a series of experiments, Dr. Leube has proved that by this method of feeding *per rectum* a considerable quantity of nitrogen is taken up into the system. In a dog, which for several days had been deprived of nitrogenous food, and whose system, therefore, was in a state of nitrogen-hunger, an increase in the nitrogen-elimination by the kidneys took place when these nutritive enemata were given; and, on the other hand, in several experiments on a dog, and likewise on a healthy young man whose system was in a state of satiation with regard to nitrogen, the quantity of nitrogen excreted through the kidneys was not materially diminished when most of the nitrogenous food was introduced by the rectum instead of the stomach. A chemical examination of the feces remaining when the food had been

retained long enough showed that almost the entire quantity of nitrogen contained in the food had disappeared. The same was found with regard to fat; and in a dog that was killed on the second day of the experiment, the epithelial cells of the mucous membrane of the colon were found filled with fat globules. Dr. Leube also relates three cases of patients in whom this method of feeding had been used, and has completely answered the expectations which had been formed from his experiments. Of particular interest is the last case, in which, in consequence of tincture of iodine having been accidentally swallowed, no food whatever could be taken by the stomach, and the feeding by the rectum had to be continued for more than four weeks. In all three cases the general condition of the patients was much improved, although the nature of the cases precluded any but temporary benefit, two of the patients suffering from carcinoma.—*Brit. Med. Journ.*, July 6, 1872.

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Dry Gangrene following the use of Carbolic Acid.—M. Poncet, an *interne* of the Lyons Hospitals, records in the *Bulletin de Thérapeutique* (July 30th) a case which he considers rightly to convey a caution against the rash use of carbolic acid by non-professional persons. A girl, aged 13, had her forefinger injured by a splinter of wood, which penetrated under the nail. The end of the finger was dipped in a bottle of solution of carbolic acid, and a compress soaked in the acid was applied. The next day the part had a grayish colour and was insensible, and when M. Ollier first saw her, a week afterwards, mortification had extended as far as the upper third of the second phalanx, and a line of demarcation was being formed. The finger assumed a mummified appearance, and separated on the thirty-fifth day. This occurrence suggested to M. Ollier the possibility of amputating fingers and toes by means of the application of carbolic acid, and experiments were accordingly made by M. Viennois on rabbits and fowls. The results showed that the application of carbolic acid was liable to be followed by toxic symptoms, but that these might be prevented by the application of a ligature. M. Ollier endeavoured to put the plan into execution in a case of disease of the great toe, by plunging it for some minutes in a concentrated solution of carbolic acid; the thickness of the epidermis, however, prevented mortification from being produced. M. Poncet records also the case of a man, aged 23, who, having wounded the end of one of his fingers, applied for ten days charpie impregnated with carbolic acid, and afterwards poultices. When he applied to M. Ollier, two months after the accident, the terminal phalanx was in a state of dry gangrene, and was removed a few days afterwards.—*Brit. Med. Journ.*, Aug. 31, 1872.

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Sudden Obliteration of the Central Artery of the Retina.—In one of the recent numbers of the *Archives de Phys.* Dr. Sichel records a very interesting case of the above lesion. The patient, aged 54, had been suffering for a long time from insufficient action of the auriculo-ventricular valves, when, after a sharp attack, she became completely blind in the right eye. Examination with the ophthalmoscope showed various small hemorrhagic spots scattered over the fundus of the right eye, and a large hemorrhagic patch in the left. The right, which at first did not permit the patient to distinguish light from darkness, improved after a few days, and then again got worse. Examination of the eye at various intervals showed a commencing atrophy of the optic nerve, and then the conversion of the artery into a whitish and opaque cord. Eighteen months after the outset of the disease the patient died, and Dr. Sichel, on examining the eye, observed an obliteration of the central artery of the retina by a clot which entirely filled up the calibre of the bloodvessel, which he believed was embolism due to disease of the mitral valve. —*Lancet*, Sept. 7, 1872.

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Incontinence of Urine in Children.—Mr. Holmes Coote administers in the above affection, with the happiest effects, even after all other treatment has failed, creasote in minim doses made into pills. —*Med. Press*, Aug. 25, 1872.

Worms in Urine and Blood.—It will be remembered that, during his investigations on cholera in India, Dr. T. Lewis discovered the embryo of a round worm in chylous urine, which is figured in his Report on Cholera. Dr. Lewis has since continued this inquiry in Calcutta, and has not only detected these embryos in large numbers in chylous urine in many cases, but has found them in very large numbers in the blood of patients suffering from chyluria. A single drop of blood from the finger has contained as many as nine live worms. And the identity of these blood-worms with those of the urine is, we understand, beyond doubt. Dr. Lewis's observations will be published in the next Report of the Sanitary Officer with the Government of India, and will be looked forward to with great interest.

A specimen of the embryo of the chylous-urine worm has been submitted to Mr. Busk, who considers it to be some kind of Filaria; and it may not be inappropriate to christen the new entozoon "Filaria sanguinis hominis." It is remarkably like some of the common tank-worms; and the mode of entrance into the body (probably with the water), its growth and increase there, and the effects it produces, are matters of the highest interest, which we hope Dr. Lewis may soon clear up.—*Lancet*, Aug. 31, 1872.

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The Bile Pigments.—By the action of sodium amalgam on an alkaline solution of bilirubin, out of contact with air, Maly (*Ann. Chem. Pharm.*, clxi., 368) has obtained a yellow colouring matter of feebly acid character, which he names *hydro-bilirubin*, and believes to be identical with the colouring matter obtained by Scherer from urine, with that obtained from feces by Vanlair and Masius, and also with Jaffe's *uro-bilin*. He assigns to it, in a later paper, the formula $C_{32}H_{40}N_4O_7$ (new notation). This direct conversion of bile pigment into urine pigment is highly interesting.—*Lancet*, Sept. 7, 1872.

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Inflammatory Agents of Pus.—Dr. Chauveau, of Lyons, pursuing his researches on the general physiology of virulent fluids, has just published in *La Revue des Cours Scientifiques* an account of several experiments made with pus. The main result of these experiments (concludes M. Chauveau) has been to show clearly that putrid pus, which induces fatal results when injected into the tissues, becomes almost innocuous when it has been perfectly filtered, thus giving evidence of the corpuscular state of the inflammatory agents of pus.—*Lancet*, Aug. 10, 1872.

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Unhealthy Revaccination.—*L'Imparziale* states, on the authority of the *Gazetta della Spezia*, that recently seventeen persons were admitted into hospital, after revaccination, with large phlegmonous swellings of the arms at the points where the operation had been performed. In one man, a sailor, sloughing took place, and was followed by death. The cases occurred in persons who were all revaccinated on the same day; and none of those operated on on other days were affected. The occurrence is attributed to bad lymph —taken probably from a diseased cow. *L'Imparziale* remarks that further information is required, before any definite conclusion can be arrived at as to the cause of the unfortunate event and the measures which should be taken to prevent its recurrence.—*Brit. Med. Journ.*, July 13, 1872.

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Women Midwives.—We extract from the *Med. Times and Gazette*, June 15th, 1872, the following remarks, which, we have no doubt, are well founded:—

"It is a matter of notoriety that, of late years, among the numerous outcries that have deafened the well-to-do population of these islands, there has been a shrill, if not a loud, one in favour of female midwives. When traced to its originators, however, it has been found to have been raised by a few male fanatics, whose objection to male practitioners is based on the fact that they credit all mankind with the same impurity which colours their own imaginings; and by a somewhat larger number of hopeless spinsters and sterile matrons, who because they are spared the burden of Eve are envious of Adam's punishment, and employ their time in prating about woman's work and

woman's mission—by which they mean the neglect of that part of the business of mankind which, in every nation and age, has been assigned to the woman, and an interference with that part which nature, custom, or the progress and necessities of civilization have apportioned to the man. Our modern prophetesses quite ignore the fact that the instinct of the human race has made a broad division in labour; that to the female part of mankind nature has assigned three very important duties, which certainly in England they do not fulfil in any tolerable fashion. The first is the duty of preparing food for the whole race; the second is that of clothing themselves and their children, if not the men also; the third is that of educating physically, mentally, and morally the young of the race. This is the true woman's work, which is utterly neglected by a large part of the sex, very badly performed by the great majority of the remainder, and only well fulfilled by the small minority that remain in so far as they profit by the assistance and imitate the skill of those males who, in sheer despair, have turned their attention to what ought to be the female part of human employment. We utterly deny that there is any appreciable call for female midwives on the part of the childbearing matrons of England and Wales. We never yet met with a woman who would not prefer being attended by a man if she could afford to pay one; and the reasons are obvious. In the first place, the instinct of the woman teaches her to rely upon the skill, courage, presence of mind, and strength of the male; in the second, she mistrusts the judgment of her sister in time of difficulty and danger; in the third, she knows that men are kinder and more considerate towards women than women are to each other. We do not believe that if all the married pregnant women in the kingdom were polled to-morrow, one in 500 would prefer being attended in her approaching parturition by a female practitioner. We allow, then, that there is an outcry for female midwives, but we deny *in toto* that it has been raised by that section of the sex which is most interested in the matter."

Hydrate of Chloral in the Prevention of Sea-sickness.—Dr. J. C. O. Will states (*Lancet*, July 20, 1872), that "during the spring of 1872 an unusually favourable opportunity for experimenting as to the value of chloral in sea-sickness presented itself, viz., an exodus of stone-cutters which took place from Aberdeen to New York, and of this I gladly availed myself. Being appealed to by a considerable number for 'a cure for sea-sickness,' I ordered in every case hydrate of chloral. Its effects were of the happiest description; for out of upwards of eighteen cases, in one only did the drug fail to fulfil the indications for which it was prescribed. The weather during all the voyage was rough, and sickness among the other passengers was exceeding prevalent. So satisfied were the men who went out first of the efficacy of the medicine they had employed, that they wrote home, directing those who were to follow to supply themselves with similar prescriptions. I may also mention the case of a young lady, a martyr to sea-sickness, who on sailing the other day had no sooner left this harbour than she began to feel sick. She therefore, according to my directions, took a dose of chloral and lay down, the result being that during the whole passage, lasting two days, she was perfectly free from her former enemy. The same result has attended many other cases in which I have given it. The dose I generally employ is thirty grains in slightly sweetened water, directing the patient to take a like quantity if relief does not follow in twenty minutes. I advise a little light, easily digested food to be taken before sailing, and direct the chloral to be taken and the patient to lie down on the first symptoms of sickness presenting themselves."

—

Death under the Administration of Chloroform.—We regret to record another death from the administration of chloroform, which took place at the Great Northern Hospital on Wednesday. The patient was a man fifty-three years of age, on whom Mr. Carr Jackson was about to perform the operation of lithotomy. The vapour was administered by Mr. George Eestes, the chloroformist of the

hospital, who has had extensive experience in anæsthetics. Mr. Osman Vincent, Mr. Vernon, and Mr. Bloxam, all experienced chloroformists, were present; but the efforts of all were unavailing in restoring the unfortunate man to consciousness.—*Brit. Med. Journ.*, Aug. 24, 1872.

Dr. Glascott exhibited to the Manchester Medical Society the heart of a man who had recently died at the Manchester Royal Eye Hospital whilst chloroform was being administered to him previous to an intended cataract operation.—*Ibid.*

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Death from Bichloride of Methylene.—The death of a patient while under the influence of bichloride of methylene occurred last week at the Bath United Hospital. A man aged 51, who had had his arm broken and his shoulder dislocated on April 29th, and who had for some time been a patient at the hospital, was about to be operated on by Mr. Gore for the reduction of the dislocation. The bichloride of methylene was given, and the patient became insensible in two or three minutes, but his face then became livid and his breathing suspended. The pulse was at the same time observed to fail. The tongue was drawn forward, ammonia was given, and the galvanic battery was used for three-quarters of an hour, but without effect. The heart was found to be large and flabby, but there was no other sign of disease in the organ. In his evidence at the inquest Mr. Gore said that, according to the records of the hospital, bichloride of methylene had been used there two hundred and fifty times in the last two years.—*Brit. Med. Journ.*, Aug. 31, 1872.

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Five Cases of Hemianæsthesia.—At a recent meeting of the Biological Society of Paris, Dr. Charcot, of La Salpétrière, gave the details of five cases of hemianæsthesia with unilateral trembling which he had observed. The patients had been all of advanced age, and had had a more or less sudden attack of apoplexy, after which hemiplegia, hemianæsthesia, and hemichorea had supervened. In three cases a post-mortem had been made, and Dr. Charcot had stated the existence of a sclerous or hemorrhagic lesion of the optic layer, radiating more or less towards the cerebral peduncles and the corpora striata. Dr. Charcot said he did not pretend to furnish the definitive explanation of hemianæsthetic phenomena, but thought he might rationally conclude, from his cases, that there existed in the nervous centres a special situation, the lesions of which produced hemianæsthesia of general sensibility.—*Lancet*, August 24, 1872.

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Character and Treatment of Malignant Scrofulous Angina.—Dr. Constantin Paul, in a long article published on the above subject in *l'Union Médicale* (number for July 23d), reviews the whole question of malignant scrofulous angina, as elucidated by the details of twenty cases which he has been able to observe. The chief points of the paper may be summed up thus: There *does* exist a malignant ulcerated angina of a scrofulous nature, the characters of which are now sufficiently recognizable to enable us to form a correct diagnosis and to prevent us from pursuing an injurious mercurial (anti-syphilitic) treatment. Cod-liver oil and the general remedies used in scrofula are to be employed. Locally, tincture of iodine and perchloride of iron have not been very successful in Dr. C. Paul's hands, but he has found the acid nitrate of mercury to be of service.—*Lancet*, August 10, 1872.

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Diabetic Phthisis.—There is some difference of opinion in respect to the real character of phthisis in diabetic subjects, some considering it to be ordinary tubercular phthisis, whilst others deny it to be such. At a recent meeting of the Société de Biologie of Paris Dr. Granchet related an interesting case of cheesy pneumonia in a diabetic sufferer, in which the post-mortem showed that there did not exist real granulations, but that the interalveolar partitions contained a considerable number of embryonic elements. Dr. Granchet argued that, if it was not well-characterized tubercle, it was at least the tubercular process, and therefore he was opposed to Lancereaux and others, who do not admit the tubercular nature of phthisis in diabetes.—*Ibid.*

Pathological Anatomy of Diphtheritis.—In a paper recently read at the Academy of Sciences (*Gaz. Hebd.*, August 2), on the "Pathology of Gangrenous or Diphtheritic Angina and Croup," MM. Bouchut and Labadie-Lagrave came to the following conclusions: In these diseases there are two kinds of anatomical lesions—the one primary, due to the ulceration of the mucous membrane or the presence of false membranes; and the other secondary, cardiac or embolic. The former are well known, but the secondary, cardiac, and pulmonary embolic lesions have not yet been described,[1] and deserve to be known, explaining as they do the occurrence of death through an entirely special lesion of the lungs and other organs. In the heart there is almost always (fourteen times out of fifteen) an *endocardite végétante* with fibrinous deposits which are the origin of frequent emboli. The lungs frequently (forty-five times out of 180) contain knots of pulmonary apoplexy or bloody infarcti, due to arterial emboli, such infarcti being sometimes colourless at the centre, and surrounded by a zone of hyperæmic pulmonary tissue. Sometimes there are knots of purulent infiltration, or even true metastatic abscesses. The lungs also frequently present at their surface, between the lobules, small venous thrombi. These bloody infarcti are sometimes found under the pericardium among the altered muscular fibres of the heart, and in the subcutaneous cellular tissue, where small metastatic abscesses may be formed. Venous thrombi exist also in the pia mater, the brain, the liver, and in different parts of the body. With these lesions there always coexists a more or less pronounced leucocytosis, which in a bad case is very considerable.—*Med. Times and Gaz.*, August 17, 1872.

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The Structure of Normal and Varicose Veins.—Dr. S. Soboroff has lately undertaken a series of researches on the structure of healthy and varicose veins, the results of which possess considerable interest. He had at his disposal eight specimens of varicose veins, which, with only one exception, were accompanied by pathological changes in the vena saphena. These were all capable of being arranged in two groups: in both the lumen of the vessels was greatly enlarged; but in one the walls were thickened, in the other they were attenuated. The preparations seem to have been prepared with great care, some being silvered, to show the epithelium; others subjected to the action of chloride of gold, chloride of palladium, and chromic acid. The principal fact that he has definitely ascertained is that a dilated venous trunk, even when possessing almost perfectly transparent walls, contains colossal muscular fibre-cells. These are so large that when first observed they were regarded as fasciculi of unstriped muscle, but more careful examination, aided by staining experiments, showed the well-marked outline of the cells and the rod-shaped nuclei, clearly demonstrating that fibre-cells alone were under the microscope. The adventitia of the thin dilated veins was thin and but sparingly supplied with vessels, and the epithelial lining of these attenuated vessels was apparently continuous and unaltered. In the thickened and dilated veins, on the other hand, the adventitia was hypertrophied, and the vessels distributed to it were large and numerous. —*Lancet*, July 13, 1872.

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The International Ophthalmological Congress.—The first session of the Congress was held in London on August 1, 2, and 3. Fifty-eight gentlemen were present. Prof. Donders was elected President, and Dr. Williams, of Boston, and M. Warlomont, of Brussels, Vice-Presidents. Mr. Hulke, of London, and Prof. Zehender, of Berne, Hon. Secretaries.

Numerous papers of scientific interest were read. The Congress adjourned to meet in New York in September, 1876.

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Alsace-Lorraine Medical Students of the Free School of Medicine.—These students have issued an address to the public, protesting against the substitution of a German faculty for that whose doors have

[1] The authors are apparently unacquainted with the observations of Dr. J. Forsyth Meigs, of Philadelphia. See *American Journal of Med. Sci.*, April, 1864, p. 305, and Jan. 1869, p. 24.

been closed. The introduction of a new scholastic programme, and of a new language is, they say, a serious blow not only to their patriotism, but to their interests, their studies, and their future. The address terminates with expressions of thanks and of veneration to their teachers who have to this period devoted their time and labour to preserve to Alsace its scientific self-government.—*L'Union Médicale*, August 10, 1872.

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Faculty of Medicine of Paris.—Dr. Brown-Sequard, the eminent physiologist, has resigned the chair of Comparative and Experimental Physiology in this faculty which he has ably filled for several years. M. Vulpian, a distinguished experimental physiologist, is an applicant for the vacant chair.

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Obituary Record. — Died in London, August 15, 1872, aged 72, Frederic C. Skey, C.B., F.R.S., Consulting Surgeon to St. Bartholomew's Hospital, well known as an able and accomplished surgeon, a popular lecturer, and the author of many valuable surgical papers.

—— In London, August 21, 1872, Alfred Poland, Esq., Lecturer on Clinical Surgery at Guy's Hospital. Mr. Poland ably edited, some years since, in conjunction with Dr. Wilks, Guy's Hospital Reports, and he contributed many valuable papers to that work, and also to Holmes's System of Surgery. He was an expert and skilful operator, and highly esteemed for his honourable career.

—— In Paris, August 23, 1872, of disease of the genito-urinary organs, Dr. P. C. A. Louis, aged 86; well known by his celebrated work on typhoid fever, and other highly important contributions to medical science which have rendered his name illustrious. He was for many years Physician to the Hôtel Dieu, was a teacher of extraordinary ability, and justly regarded as one of the greatest authorities of his day, and that too at a time when Paris could boast of so many eminent physicians.

—— In Paris, August —, of disease of the heart, in the 59th year of his age, Eugene Napoleon Vigla, Physician to the Hôtel Dieu.

—— In Paris, July 5, 1872, of heart disease, M. Charles Pierre Denonvilliers, aged 64. M. D. was appointed by *concours* Professor of Anatomy in 1846, in succession to Professor Breschet. In 1856 he succeeded Professor Gerdy to the chair of Surgical Pathology. In September, 1865, he was appointed to the Professorship of Operative Surgery, which became vacant by the death of the illustrious Malgaigne; and in 1867 he was promoted to the chair of Clinical Surgery at the Hôpital la Charité, which he held till the end of last year, when, having attained the age of 63, he had to retire, according to the rules recently established for hospital physicians and surgeons.

M. Denonvilliers, though a talented man and a practical surgeon, had not distinguished himself much as an author. He, however, contributed largely to the medical periodicals of the day, and wrote two very excellent works—one entitled "Compendium de Chirurgie," in conjunction with M. Gosselin; and the other "Rapports sur les Progrès de la Chirurgie," which appeared in 1867, and in which he was assisted by Nélaton, Velpeau, and others. He was for his services appointed in 1845 "Chevalier" of the Legion of Honour. In 1857 he was promoted to the rank of "Officier," and in August, 1865, to that of "Commandeur." He was, besides, Inspector-General of the medical branch of Public Instruction.

—— In Paris recently, Dr. M. Bousquet, one of the most eminent of the promoters of the Jennerian doctrines in France, aged 76, long since retired from practice with a good competence, which he has devoted to the erection of and providing for a hospital. In medical history he will be remembered as one of the most able and determined opponents of Broussais in the pages of the *Révue Médicale*, between 1820 and 1830, and therefore when the great antiphlogistic advocate was at the height of his popularity. Bousquet's "Traité sur la Vaccine" is one of the best works upon the subject, and has done immense service to the cause he had so much at heart, and which he defended to the last when it was threatened by the inroads of "animal vaccination."

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CLINICS.

CLINICAL LECTURES.

Clinical Lectures on Strangulated Hernia. Delivered at St. Bartholomew's Hospital. By Sir JAMES PAGET, Bart., V.P.R.S., Consulting Surgeon to the Hospital. (Continued from page 165.)

LECTURE III.—The design of the operation for hernia is to divide the structures which tightly gird the protruding parts, so that these may be returned, these structures, forming what is called the stricture, are in some cases outside the hernial sac; in some, in its very substance; and, according to these and other differences, the operation may in some cases be completed without opening the sac, and in other cases must include this opening. The advantages of the two methods have been often discussed, and I may begin by speaking of them.

There can be no doubt, I think, that if all the rest of the operation were always the same, the advantage of reducing the hernia without opening the sac should always be sought. Thus to reduce a hernia is the next best thing to reducing one without any operation at all. The structures divided externally to the sac are insignificant, and it might be difficult to name an operation less endangering either life or health than this would be. The peritoneum is not wounded; the intestine and omentum are not touched or exposed to air; the wound may be small; any hemorrhage may be easily stayed, and must be all external. Thus the wound

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is favourable for speedy healing, and crysipelas or any other mischief is not likely to extend to the peritoneum.

These are sufficient reasons for always wishing and generally intending to operate without opening the sac, especially in old and feeble people and in case of large herniæ. But you must not let your wishes carry you too far. They may lead you into great mischief. For, first, there are many cases in which the contents of the sac are not fit to be returned into the abdomen—for instance, when they are sloughing, or deeply ulcerated, or strangulated within the sac. The risk of returning these is so much greater than that of opening the sac, that you should not hesitate to open it whenever you have any, even slight, reason to suspect any of these conditions of the sac's contents. And such conditions there must always be in these sets of cases—1, in those in which the strangulation has existed long, say four or more days, whether with slight or severe symptoms; 2, those, of whatever date, in which the signs of strangulation are very acute; 3, those in which there are very marked signs of advanced or low inflammation in and about the sac; 4, those in which the contents do not go back easily and within two or three minutes after all stricture is fairly relieved. And, in measuring this ease of going back, you must be scrupulous; for I have certainly done harm and seen more done by trying too long to reduce herniæ without opening the sac—fingering and clearing the parts, and pressing them many times; damaging intestine, and exciting suppurative inflammation all about the sac; so that, when at last the operation was completed, much more mischief had been done than if the sac had been at first straightforwardly opened.

I think, then, you may take this as a safe rule in all ordinary cases: intend to complete the operation without opening the sac, but give up your intention if you find any reason to suspect complications, or very morbid states of the parts within the sac, or any such difficulties as would lead to the use of forcible or long-continued efforts at reduction. Of course, the more you practise the operation, the less frequently will these difficulties hinder you; but you may keep to the same rule, and think it wiser to avoid difficulties than at all cost to overcome them. And, finally, when you are in doubt, open the sac; for, though the advantages are, on the whole, clearly in favour of not opening the sac, yet the amount of advantage is not so great as to justify any considerable risk for it. Rough statistics of operations are not to be taken as measures of this advantage. In the worst cases, the sac must be opened; and, of these, a large portion die without any regard to the manner of the operation.

As to the method of operating, there are many, and some good anatomical rules, on which I shall not touch. They are admirably laid down in Lawrence on *Hernia*. I will only give some general rules, such as may be useful in nearly all cases.

In all, you should decide at first if possible, whereabouts the stricture is, so that your first incision may be fairly over it, and give you room to act on it without needless length of cutting. In femoral hernia, you may be sure that the stricture is at, or within half an inch of, the femoral ring; and this is near enough for guidance for the first incision. So, in umbilical hernia, the mouth of the sac is always the seat of the stricture; and the middle of your first incision may be right over it. In inguinal hernia, the stricture is, in the large majority of cases, at or within the internal inguinal ring; and the incision should extend from the internal ring to beyond the external ring, and (according to the characters of the hernia) to a greater or less distance towards or along the scrotum. But, in inguinal hernia, the stricture may be at the external ring, or, being formed by the thickened mouth of the sac, may be pushed up towards the abdominal cavity, or down along the canal, or beyond the external ring to some distance in the scrotum. Moreover, in some rare cases of congenital hernia, there may be two strictures—one at each end of the open canalis vaginalis. For these cases, it is useful to apply a rule devised, I think, by Mr. Luke, for ascertaining the seat of stricture;

namely, to observe at what point along the course of the hernia the impulse on coughing ceases. For, when a hernia is strangulated, the impulse can be felt as far as the stricture; beyond that, it cannot be felt: therefore, where the impulse ceases, there probably is the stricture; and this part must be fairly included within the length of your incision.

In femoral hernia, your first incision may be vertical, in a line drawn straight down from the spine of the pubes—a projection which you can always easily feel. This incision seldom needs to be more than an inch and a half long, and may sometimes be less. In umbilical hernia, a vertical incision of an inch and a half or two inches will suffice, in the middle line, so as to reach either the upper or the lower border of the mouth of the sac. But I am disposed to believe, though I have not tried it, that, in large umbilical herniæ, two incisions, going to opposite borders of the ring, would be better than any one. In inguinal hernia, the incision should take the direction of the neck and upper part of the hernia, and its length must vary according to the size of the parts to be returned.

Through these incisions you must go on and on, through the several layers which your anatomical dissections of healthy parts will sometimes enable you to recognize, till you come to the sac. The thickness of these layers is more various than you may suppose. Especially in small femoral herniæ, you will often find an unexpected quantity of fat about the sac; and in umbilical herniæ, very much more fat about the mouth of the sac than the thinness of the integument over it would at first suggest.

Through whatever thickness, you must continue cutting in the same direction; and when you are fairly on the surface of the sac, keep to the same line. Do not clean the whole front of the surface of the sac; do not separate it from the surrounding textures. No good can come of this, but much harm may. You want nothing more than a linear division of the stricture, whether with or without a linear opening of the sac. All that is done on either side of this line is useless or mischievous.

When you have thus fairly reached the sac, and have exposed its neck and mouth or narrowest part, you must proceed differently, according as you propose to complete the operation without or with an opening of the sac. In the latter case, you open the sac first near its mouth, and then along the length and full extent of your external incision; and then divide the stricture from within. You may do this on your finger-nail or a director, and with cares about the intestine and other structures, which are insisted on in all handbooks. In the former case, when you intend not to open the sac, you must find where the stricture is, and divide it outside the sac.

Among femoral herniæ, there are differences as to the seat of stricture which I cannot explain to you, but which my cases made very clear to me. In some instances, as you trace up the neck of the sac, you find it tightly banded across by the layer of fibrous tissue called Hey's ligament—a layer traceable as a falciform edge of the fascia lata, where that fascia is connected with the crural arch, and is thence continued to Gimbernat's ligament, bounding the upper part of the saphenous opening.

Sometimes a fair division of this layer of fibres up to the edge of the crural arch is sufficient to render the hernia reducible; and here, with the reduction, should end the operation. But, with more cases, this is not sufficient; and you may feel the stricture formed by bands of fibres which encircle the neck of the sac, and which must be divided, band by band and layer by layer, till none can be felt. These fibres are, I believe, bands of tough connective tissue, belonging to the cribriform fascia, through which the hernia has protruded. Very rarely, however, even the division of these, and of Hey's ligament too, is not sufficient; for the stricture is formed by thickening of the mouth of the sac itself. This condition, which is the common cause of stricture in inguinal hernia, is very rare in femoral; but it certainly does occur; and, in any case well suited for the operation without opening the sac, you may try to thin the mouth of the sac without opening it, and thus to

make it extensible enough for the return of its contents. You may try this; but, let me add, the chances of success are small. You are much more likely to cut into the sac at some thin place; and, when you have done this, you may as well enlarge the opening and divide the stricture from within.

It is this uncertainty as to the exact cause of stricture in strangulated femoral hernia, which makes it advisable to put on a strong resolve not to use too much time or force in endeavouring to operate without opening the sac. You will be apt to think, when you have divided one thing, that now you will be successful; and you try to press back the bowel. But you fail; and then you divide something else, and try again; and now again you fail. And thus you may go on, till you have done more harm than you would have done by a straightforward opening of the sac and immediate easy division of its stricture and return of its contents. Keep this in mind, that an easy reduction from an open sac is better than a difficult reduction from a closed one.

In umbilical hernia, the case is simpler. The stricture is always in the tough fibrous tissue of the sheath of the rectus. When you have reached this, commonly going much deeper through fat than you would expect, and not only deeper, but further under the sac, you may be able to divide the stricture without opening the sac; but this is difficult, for the sac is very thin, and there may be little tissue between it and the fibrous ring. Still it is well to try, but not too long. You are more likely to open the sac at or close by the stricture; and, if you do this at all, you may as well save time and force by opening it more widely.

In inguinal hernia, the stricture is in many cases, and was in the majority of those on which I operated, formed by the mouth of the sac, thickened and hardened by what appears to have been an inflammatory process, producing a scar-like and contracting tissue. This tissue forms a band about a fourth or a third of an inch in width, and about a line in thickness, and sometimes has a thin sharp inner edge. By the way, let me say that the formation of this band is not the result of wearing trusses. I have seen it very marked in patients who never wore a truss; and I have seen the sac thin and soft in every part in those by whom trusses have been long worn. But, however it may be formed, this annular thickening and contraction of the mouth of an inguinal hernial sac is a common cause of stricture. On account of it, you should proceed at once to expose the mouth of the sac; unless, indeed, you should have found the tissues outside it so tight that you may fairly believe the division of them will be sufficient for permitting the reduction of the hernia. When you have exposed the outside of the thickened mouth of the sac, you may still achieve the reduction without opening, by gradually thinning the mouth—dissecting off band after band from any portion of it. Sometimes the mouth will yield sufficiently at a part thus thinned to stretch and allow the reduction; but more often, I think, you will fail, and will have to open the sac and divide the stricture from within.

Here, as with femoral hernia, be scrupulous not to spend more than fair force and time for the sake of the reduction without opening the sac. It is a good thing to succeed; a bad thing to fail. You must measure how much risk of harm it is right to incur for the hope of doing good.

If the reduction be accomplished without opening the sac, you will have attained the best immediate object of the operation; but remember that fallacies of reduction are possible here as well as in the cases in which no operation has been done; they are, however, less mischievous, for, if the stricture be completely divided, there will be no strangulation of whatever remains in the sac. Especially you must have no fear if, as commonly happens, after returning intestine, some omentum remain in the sac. This will do no harm; but, if more than omentum have remained in the sac, and the signs of strangulation be not relieved or lessened, you must operate again and open the sac, regarding these cases in the same light as those of partial or doubtful reduction, of which I spoke in the last lecture. But, suppose the sac

opened, as it should be in nearly all bad cases, and in many which, though they are not bad, yet may be called difficult, here may occur the most difficult question of all. What is to be done with the contents of the sac? Of course, in most cases you are to return them; but in many you are not, and which are which?

Look first to the character of the fluid which, in most cases, you will let out of the sac. In most cases, not in all; for, in some small femoral herniæ, especially in very thin dry people, and in many umbilical herniæ, and in any that contain a large quantity of omentum, there may be no fluid, or too little to be distinctly seen, but if there be enough to judge from, you may deem it a good sign if the fluid is clear, and yellowish like serum, or rather like liquor sanguinis—for it will coagulate spontaneously. This indicates only such an exudation of fluid as may come from a simple congested piece of intestine or from a piece not badly inflamed; and the cases would be very rare, if there can be any, in which intestine found behind fluid such as this might not be returned. The same may be said when with fluid such as this there are flakes or bands of lymph or fibrinous exudation; for these tell of only such inflammation as may safely be recovered from when the intestine is returned. I am disposed to say the same of the cases in which the fluid is clear, but more or less deeply blood-stained; for this exudation of blood-cells or blood-colour is not characteristic of any serious morbid change in either the sac or its contents. But when the fluid of the sac is turbid, brownish, muddy, it tells of more advanced changes in the intestine or in the omentum; and the further it goes in this direction the more carefully must you consider whether these are in a fit state to be returned. You will probably have to decide that they are not fit, when the fluid has a distinct fæcal or putrid odour; and of course they are not fit when the fluid has fæcal matter mixed with it.

I do not venture to say that the characters of the fluid contents of the sacs of strangulated herniæ are to be absolutely relied on as guides for practice; but they are good evidence to be taken into the general account, for they fairly represent the state of mere congestion or inflammation, or more or less advanced decay or decomposition, or giving way of the walls of the strangulated intestine and omentum.

Not rarely, when you have divided the stricture and returned the contents of the sac, fluid runs from the peritoneal cavity. I do not know any rule of practice but that you must let it run as long as it will, and, if it be of very unsound appearance, not close the wound till the fluid has ceased to flow, if even then.

As to the omentum which the sac may contain, and what to do with it: if there be a small quantity—say two or three square inches—and this be not adherent, and not more changed than by congestion or slight inflammation, there can be no question that you are to return it after the intestine; and if there be a piece of even very large size, and not more changed in texture, you had better return it if you can without much force or expense of time. But it sometimes happens, when the abdomen is tense with over-filled intestine, that you cannot return a large piece of omentum without much difficulty. What then? shall you cut it off or leave it in the sac? I advise you to leave it. I believe that the cutting off, with the necessary ligatures or other fastenings of vessels, adds to the dangers of life; while the leaving of omentum is only sometimes followed by greater difficulty in the fitting of a truss—a difficulty which is not great enough to justify any risk of life.

Still more may this rule of leaving omentum in the sac be observed when a large piece of it is hardened and thickened as by old disease. When a small piece is thus changed you may, I believe, return it.

When omentum is adherent to the sac, but in other respects fit to be returned, you should break the adhesions and return it, after stopping all bleeding. If it be not fit to be returned, leave the adhesions, and in any case do not break adhesions so near the mouth of the sac that their vessels are likely to bleed into the abdominal cavity.

When omentum is sloughing, or nearly sloughing, leave it, that it may cast its sloughs outward.

But the chief questions in these operations are concerned with the state of the strangulated intestine and the manner of dealing with it. You are to judge chiefly from the colour and the tenacity. Use your eyes and your fingers; sometimes your nose; very seldom your ears, for what you may be told about time of strangulation, sensations, and the rest is as likely to mislead you as to guide aright.

As to colour, any tint from the natural gray through various shades of rosy or ruddy pink, or redness, up to the deepest crimson, even verging to blackness, may be consistent with fitness for returning of the intestine, if the texture be good. All these tints may be due to congestion and stagnation of blood, or to extravasation of blood into the intestinal walls; and all these may have been without such inflammation as would spoil the texture of the intestine, and may not have endured long enough to kill it. I am disposed to say that you may return intestine of any colour short of black, if its texture be good; if it feel tense, elastic, well filled out, and resilient, not collapsed or sticky; and the more the surface of the intestine shines and glistens, the more sure you may be of this rule.

When a piece of intestine is thoroughly black, I believe you had better not return it, unless you can be sure that the blackness is wholly from extravasated blood. It may not yet be dead, but it is not likely to recover; and, even if it should not die after being returned, there will be the great risk of its remaining unfit to propel its contents, and helping to bring on death by what appears very frequent—distension and paralysis of the canal above it. But, indeed, utter blackness of strangulated intestine commonly tells of gangrene already; and of this you may be sure if the black textures are lustreless, soft, flaccid, or viscid, sticking to the fingers or looking villous. Intestine in this state should never be returned.

Colours about which there can be as little doubt, for signs of gangrene, are white, gray, and green, all dull, lustreless in blotches or complete over the whole protruded intestine. I cannot tell why there should be so many colours in different cases, or sometimes even in the same case; but all are alike certain signs of gangrene, and they are always combined with loss of due tone and texture of the intestinal wall. Intestine with these marks, even though they be small, must not be returned.

Then, as to the texture of the protruded intestine: it should be, for safety of return, thin-walled, firm, tense, and elastic, preserving its cylindrical form, smooth, slippery, and glossy. The further the intestine deviates from these characters, the more it loses its gloss and looks villous, the more it feels sticky, and is collapsed and out of the cylinder form, the softer and more yielding, the more pulpy, or like wet leather or soaked paper, the less it is fit for return. And when these characters are combined with so many colours as I have described, the intestine must be taken to have perished, and had better be laid open, that its contents may escape externally and do no harm.

But, short of gangrene, there may be ulceration of the walls of the intestine. The usual place for this is where the intestine is girt by the mouth of the sac, and it is most frequent in femoral herniæ long strangulated. In these it is especially the sharp hard edge of Gimbernat's ligament, which seems to cut into the intestine, thinning its wall and at last piercing it: and the chance of this having happened is enough to justify the rule that, where the strangulation has been sharp and long, the intestine should be gently drawn down after the stricture is divided, in order to see that there is no great injury of its walls where the chief pressure of the stricture has fallen on them.

Here too, because they are similarly dangerous to life, I might speak of laceration of the intestine in too violent attempts at reduction, or wound of it in operation; but I have no personal experience of such cases, and can add nothing to what you may read in the best treatises on hernia—such as that of Sir William Lawrence, or in the chapters devoted to hernia by Mr.

Erichsen in his *Science and Art of Surgery*, or by Mr. Birkett in Holmes's *System of Surgery*. These will supply you not only with their authors' experience, but with what they have gathered and set in order from the writings of others. Limiting myself to what I have studied in my own cases, I must omit many things besides ruptured and wounded intestine; such as the various complications of strangulated hernia with hydrocele and misplaced testicle, with varicocele, and with accidents of the operation, such as hemorrhage from the epigastric or the obturator artery. Some of these things I have never seen; others I have seen only once or twice, and have learned concerning them nothing but what you may learn by reading the works to which I have referred you.

But, as to the treatment of sloughing and ulcerated intestine of which I was just speaking, I will only say that it has always seemed to me more prudent to incur a great risk of having a permanent external fæcal discharge by leaving the intestine at the wound, than to add to the risk of life by returning any thing which it may seem possible to repair by suture or any such means. Of course, these means are not to be thought of if the sloughing or ulceration be of more than very small extent; but even in the smallest, unless in some very rare cases, I would not add to the inevitable risks of life by returning the damaged intestine. In cases of hernia, the saving of life is so much more important than anything else, that we ought not to incur a risk of life for anything less than the highest probability of saving a patient from some life-long distress.—*Brit. Med. Journ.*, May 18 and June 1, 1872.

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Extract from a Clinical Lecture delivered at the London Hospital on Affections of Hearing in Cases of Disease of the Nervous System. By J. Hughlings-Jackson, M.D. —It is now evident enough that there are many nervous diseases which we cannot study methodically unless we examine the deep parts of the eye. Amaurosis, when its nature is revealed by the ophthalmoscope, is one of the most important of all nervous symptoms. It is to be regretted that in spite of the careful works of Wilde, Toynbee, Hinton, Politzer, Von Tröltsch, Moos, and others, we know so little of the symptomatic value of deafness in cases of cerebral disease. There are two reasons for this—(1) There are difficulties in defining the nature and exact seat of the changes on which deafness depends. When a patient becomes blind, we can determine at any rate whether his blindness depends on changes in the optic nerve and retina, or on changes in the apparatus accessory to these percipient parts. But in cases of deafness it is very difficult to tell whether the pathological change is in the auditory nervous[1] system or in the accessory apparatus of hearing. Tröltsch (I quote from St. John Roosa's translation) says (there are no italics in the original)—"The diagnosis of nervous deafness will be the oftener made the *less* the surgeon is able to distinguish the different affections, the *less* he understands how to examine the affected portions, and the *less* knowledge he has of the pathological changes of the external and internal ear." And again, "Let us confess, gentlemen, that we are apt to call those affections 'nervous' which we can neither diagnosticate nor improve by treatment." This is a very unfortunate state of things, but it is due to difficulties inherent in the subject, and not to want of work or skill on the part of those who have especially studied diseases of the ear. From our inability to decide in a case of disease of the nervous system whether the patient is deaf from disease of some part of the auditory nervous system or from disease of the accessory apparatus of hearing, the statement that he is deaf is one of little point in the list of symptoms of his case. (2) In those cases where the deafness is a subordinate symptom (for example, in a case in which there is deafness with palsies of cranial motor nerves), there is not enough precise work done either in establishing the nature of the deafness

[1] I use the expression "auditory nervous system" to include the auditory nucleus, the auditory nerve, and its peripheral expansions in this labyrinth. The expression "optic nervous system" includes the corpora quadrigemina, optic tracts, optic nerves, and retinæ.

during life or in noting the appearance in the ear and its nerves found post-mortem. Thus many valuable facts are lost. I now write because I wish to urge that in physicians' practice a good field will be found for the precise study of the various causes of deafness.

Physicians see cases in which deafness is associated with other and more easily understood nervous symptoms. Again, in physicians' practice, from the greater gravity of the cases, post-mortem verification or disproof of the conclusions which our examinations of the ear have led us to is to be more often obtained.[1] There is one thing which can be safely stated—namely, that deafness, presumably of nervous origin, is rarely met with in cases of intracranial disease of any kind; but since it is, as we have seen, very difficult to tell whether a patient's deafness is of nervous origin or not, this statement is not definite. We can, however, make the wider statement that deafness of any kind (excluding cases *manifestly* due to disease of the apparatus of hearing, cases with discharge from the meatus, or cases with severe pain) is a rare complication of intracranial disease. It is very much less common than amaurosis (from optic neuritis). This fact, whatever its explanation may be, is evidently one of importance. To take a particular illustration: In cases of adventitious products in the cerebral hemisphere we nearly always find blindness,[2] partial or total, from optic neuritis. But in no case have I ever seen deafness the result of adventitious products, nor of any other sort of disease in any part of either cerebral hemisphere. (*I speak only from cases completed by autopsy.*) I have, however, seen only one case recorded (Royal London Ophthalmic Hospital Reports, vol. iv., part iv., p. 420) in which, with tumour of the left cerebral hemisphere, there was complete deafness of both ears. But this case was not exceptional, as there was also a tumour the size of a hazel-nut at the point of junction of the pons and medulla oblongata on the left side. In the Royal London Ophthalmic Hospital Reports, vol. v., part iv., I published a case (there numbered xxi.) of a woman, 18 years of age, who was blind and deaf. She had also a reeling gait. I remarked of her case (p. 281, *op. cit.*)—"I think the disease must be chiefly of the left cerebral hemisphere, and probably of its anterior lobe; but I equally think there must be disease lower down, and away from the cerebral hemisphere, to produce the deafness—for, so far as I know, deafness to any considerable extent (I now say to any obvious extent) does not occur from disease of the cerebral hemisphere." This woman died about five years later, under the care of Dr. Claye Shaw, in the Metropolitan Asylum, Leavesden. He was so kind as to show me the tumour. It did not, as I had supposed, actually involve the cerebral hemisphere, but it grew from the floor of the sphenoidal fossa, and thus must have interfered with the hemisphere by pressure at least; moreover, the disease was on the right side. The only reason I had for thinking it to be on the left was that I had been told that the girl had had a *right*-side seizure, doubtfully epileptiform. But the point of importance for my present subject is as to the deafness. There was but one tumour; not two, as I imagined. But *in effect* there were two lesions, as the tumour extended so far back as the seventh pair of nerves. There was affection of the hemisphere (the patient had become insane) by the tumour, and the auditory nerve was *reached by it*. But it must be remarked that Dr. Claye Shaw found no palsy of the parts supplied by the portio dura, which nerve also must have been in the way of pressure.

My impression is that deafness does not result from intracranial tumour (or other

[1] In the "Archives of Ophthalmology and Otology," vol. ii., No. I., appear two papers on affections of the ear, which have as much interest to physicians as to aural surgeons. One is, "A Clinical Analysis of the Inflammatory Affections of the Inner Ear," by H. Knapp; the other is, "On Vertigo occurring in Affections of the Ear," by Gustav Brunner, of Zurich, translated by Emil Gruening, of New York. A perusal of these papers will, I think, convince any one that careful investigations of aural symptoms are of very great value in the elucidation of some obscure nervous affections.

[2] As is well known, there may be optic neuritis without obvious defect of sight, but blindness, partial or total, occurs nearly always before death.

kind of adventitious product) unless the auditory nerve is actually involved or directly pressed on. If so, its significance is altogether different from that of amaurosis from optic neuritis—as in optic neuritis the adventitious product scarcely ever directly involves any part of the optic nervous system. Again, if the fact be as I suppose, deafness is a localizing symptom, whereas, so far as is yet shown, amaurosis from double optic neuritis is of no value whatever in localization. Optic neuritis occurs from tumour in many parts, probably in any part of the encephalon.

In both the above-mentioned cases the tumour could have affected—affected directly, that is—but one of the auditory nerves, and yet the deafness was double. I cannot explain the occurrence of *double* deafness in these cases. Transmitted pressure seems at first glance to offer an explanation, especially as the auditory nerves are soft; but this explanation is not satisfactory. And I have (*Medical Times and Gazette*, June 17, 1865) recorded a case of tumour[1] the size of a walnut, which grew from the front part of the left lobe of the cerebellum, in which case there was deafness of that side only.

To discover how it is that disease of the hemisphere so often causes amaurosis, whilst it never causes deafness, we must consider how the word "cause" is here used. We cannot suppose that whilst the optic nerves have connections with the cerebral hemisphere the auditory have not. Probably the auditory nerves have very indirect connections; but connections of some kind they must have, or we must assume that speaking and singing are not dependent on action of the cerebral hemisphere.

[1] The tumour had flattened the fifth nerve; the portio dura nerve ran into the tumour, or was lost on it. The strange point of the case is that the fifth and portio dura nerves were not paralyzed. My last examination of the case was on December 1, 1864. The patient died February 23, 1865; but Mr. Stephenson, under whose care the patient was, noted no change in the symptoms, except that the patient passed urine and fæces in bed. The deafness was present when (September, 1864) I first saw him. We know that nerves will bear slowly exerted pressure very well, but probably this does not apply to the soft auditory nerves.

The disease of the cerebral hemisphere, so far as it destroys, may cause no obvious symptoms of any kind; but if the destroying agent be tumour or other kind of adventitious product, it leads to secondary changes and optic neuritis in one part[2] of the secondary changes, and fortunately a visible part. How these secondary changes are produced is at present unknown. In the mean time there are several speculations. It would be foreign to my subject to go into these speculations here; I will only mention that I believe the distribution of arteries will be some help to the solution of the difficulty. Whatever the explanation may be, the facts that while blindness often occurs by some process from adventitious products in the cerebral hemisphere, deafness never results from disease of any kind of any part of either hemisphere, are of great importance.

That there may be an auditory neuritis analogous to optic neuritis, it is scarcely worth while in the present state of things either to affirm or to deny. If there is, it may be supposed to depend on disease of the cerebellum. But what we have said of the cerebrum applies to the cerebellum. Vulpian remarks that nothing is rarer than trouble of hearing in alterations of the cerebellum. I have never seen a case of double deafness from tumour of the cerebellum, and yet in nearly every case there is amaurosis (from optic neuritis). In some of these cases, when the tumour is of the middle lobe, there is manifestly increased pressure, not only under the tentorium, but above it; for a tumour here placed will lead to hydrocephalus by interfering with the free return of blood from the lateral ventricles of the cerebral hemispheres. Yet in such cases—I have seen four—there was no deafness.

In cases where there is disease of the tympanum we frequently have nervous symptoms; but these are the result of the ear disease—obviously so in cases of cerebral or cerebellar abscess. I have elsewhere (*British Medical Journal*, June 26,

[2] Other secondary changes are in gray matter of convolutions, on which convulsions are dependent.

1869) remarked on the association of epilepsy or epileptiform seizure with discharge from the ear. It is manifestly difficult to say that there is more than a coincidence. But in diseases so painfully obscure as epilepsy or epileptiform seizure we cannot afford to overlook any realistic condition. We should inquire for earache and discharge from the ear in all cases. At any rate, it is as important to do this as to inquire for worms and other eccentric irritating causes. In all cases of recurring epileptiform seizure we are sure that there is an irritable condition of nerve-tissue somewhere. This is certain, whatever else is doubtful. The great difficulty is to learn by what *pathological* process that irritability results. The irritability may result from different kinds of pathological processes. I imagine that embolism and thrombosis occasionally lead to it, and thus in epilepsies I inquire for heart disease, rheumatism, and scarlet fever; and, since I imagine it may result from *venous* thrombosis, I inquire also for discharge from the ear. Since I have had no post-mortem examinations, I do not pretend to *know* that there is such a relation.[1]

I do not suppose that the ear disease leads to the epileptiform seizure by reflex action, but as seen by the gross process of thrombosis. I mention this expressly, as Knapp (who has only seen extracts from my paper in the *British Medical Journal*) quotes me, along with Köppe and Schwartze, as having published observations "which seem to demonstrate that reflex epilepsy may be occasioned by inflammatory disease of the middle and inner ear." This may be the connection —if connection there really is—betwixt the ear disease and epileptiform seizure; but I do not think it is. However, as I say, I have had no autopsies, and I can therefore only urge that discharge from the ear should be one of the things to be investigated in cases of epilepsy and epileptiform seizure.

It will, however, be of comparatively little value to note the connection unless we note also the *kind of seizure* with which the discharge occurs. By "kind" I mean the region affected; whether, for example, the convulsion is sudden and universal, or begins deliberately in one side of the body —viz., in the face or hand—and may or may not become universal. In many of these cases the convulsion begins suddenly, and we learn from the patient little more than that he has had a severe fit. But in some cases it begins deliberately on one side, and occasionally there is after the seizure weakness of that side. (I have recorded such a case—St. Andrew's Reports, vol. iii., 1870, "Study of Convulsions," Case 6.) An autopsy on such a case would be very important; for it is certain that in such cases there is *local* disease, and indeed, I think, certain that there is disease in the region of the corpus striatum on the side opposite the side of the body in which the fit begins. And of course it is a truism to say that the fit depends on irritability of nerve-tissue. There is irritability of nerve-tissue in the region of the corpus striatum. The missing link is the *pathological process* by which that local irritability results. When we find that the aural discharge is only of the ear on the side opposite the side of the body in which the fit began—that is on the side of the brain—the possibility of the relation need not be lost sight of, with a view to post-mortem verification or disproof.

I have mentioned that occasionally after convulsions beginning unilaterally (hand or face, and probably in foot) there is hemiplegia; that hemiplegia after a convulsive seizure is often slight, and nearly always transitory. In some cases of discharge from the ear—I speak only of children—there is persistent hemiplegia. St. John Roosa has recorded an important case of this kind. I have seen a good many cases, but as I have had no autopsy I will content myself with urging that in all cases of hemiplegia in children the ear should be examined, and with asking that in cases of autopsy on hemiplegic children the possibility of venous thrombosis from ear disease be borne in mind.—*Med. Times and Gaz.*, July 13, 1872.

[1] I have, however, published a case which seems to lend support to that view. There was in that case no discharge from the ear, but the lateral sinus contained purulent matter.

HOSPITAL NOTES AND GLEANINGS.

Notes of a Visit to the Surgical Wards of Dr. Léon Labbé.—In the course of a visit to the wards of Dr. Léon Labbé, at the Hôpital la Pitié, we noticed various interesting cases or surgical facts, of which the following is a brief account:—

Case of Lipoma; an Easy and Practical means of Diagnosing Lipoma.—The case was one of a woman of middle age, on whose left shoulder, superficial to the deltoid, was seated a tumour of about the size of an orange. There was some difference of opinion among the visitors in regard to the nature of the growth, a few thinking it was a cyst, whilst the majority diagnosed a lipoma. Dr. Léon Labbé laid stress on an easy and practical means of making out lipoma. It consists in squeezing and gently raising the skin around the tumour. It follows that the surface, which was before quite smooth and equal, becomes slightly red, whilst the interstices between the lobules of the fatty tumour are marked out by white lines. The appearance thus afforded is quite characteristic of lipoma.

Sub-deltoid Cyst.—Near to the preceding patient was another woman who a few days before had been operated upon for a similar tumour, also situated on the left shoulder. In this case, however, the growth was seated under the deltoid. An exploring puncture had been previously made, and the tumour afterwards removed with the knife. It was a synovial sub-deltoid cyst. The patient was doing well when we saw her.

Amputation of the Thigh; Dressing with Cotton-wool.—This was quite a typical case of dressing with cotton-wool (now extensively employed in the Paris hospitals), and its favorable results. The patient was a girl of about sixteen or seventeen. This was the eighteenth day after the operation. The girl was almost in a dying state when amputation was decided upon. She had a white swelling in the knee, and a large abscess in the periosteum was found loosened and detached up to the middle of the thigh. Hectic fever had already set in, and the girl's strength was fast wasting away. On this, the eighteenth day of the operation, the patient looks quite well and cheerful. She has grown fat, and the cheeks are round and rosy. A large heap of cotton-wool had been applied in successive layers immediately after the operation, and strong compression exerted as usual by means of cotton-bands. The dressing had not been removed since, and will not be removed until about the thirtieth or fortieth day. As there was some slight smell a few days ago, with a little oozing of pus through the dressing, starch with carbolic acid was applied, and there is now no smell perceptible. The cotton dressing looks tight, compact, and clean. The stump may be moved about without the patient experiencing the slightest pain or inconvenience. This kind of dressing should prove useful in ambulance work during war. There has been no traumatic fever. From the day of the operation the patient rapidly recovered her appetite and gained strength.

Dr. Labbé explained a few points connected with the mode of dressing. All the arteries, large and small, must be tied. The wound is simply stuffed with cotton, which during the process of suppuration and healing is gradually and completely pushed out. Circular amputation is more convenient than the flap operation, though flaps are no impediment. The wound need not be washed with carbolic acid or any other disinfecting fluid. Large heaps of cotton-wool must be applied, and strong compression with the cotton bands is necessary.

Dr. Labbé referred to an addition which Dr. Ollier had proposed to apply to this mode of dressing, and which had turned out a complete failure—namely, the use of silicate of potash added to the bands for the purpose of fixing the dressing. The cause of failure is this: It always happens that the cotton-wool swells after twenty-four hours—becomes *tassee*, according to the French expression. The cotton-bands are, therefore, loose, and require to be tightened. This is quite impossible with the silicate of potash.

Sebaceous Cyst of the Head.—In these cases Dr. Labbé uses Vienna caustic, which he applies all over the tumour ex-

cept within two or three millimetres of the base. The tumour dries up after a few days, and then falls, leaving only a white cicatrix. There is no danger of erysipelas.

Stricture and Retention of Urine; Hypogastric Puncture.—This was an illustrative instance of the utility of puncturing the bladder with the aspirating apparatus, in stricture and retention. The day after the puncture had been made and the bladder emptied, a small bougie was introduced and gradual dilatation made, with successful results. No local effects of the puncture are perceptible.

Division of Sciatic Nerve in a Youth by a Bullet.—There exists paralysis of the limb and contraction of the tendo-Achillis.

Enlargement of Great Trochanter for eighteen years; Removed by the Gouge and Hammer.—Guérin's cotton-wool dressing was applied with good results. The operation was performed in the latter end of January. The actual cautery has been since occasionally applied. The patient is doing well, and healing is almost complete.

Atrophy of the Deltoid after contusion of the Muscle.—Electricity has until now been used in vain.

Aspirating Puncture of the Knee in a case of Hydrops Articuli.—The case was caused by a fall on the knee. The patient is a lad of about sixteen. Two punctures with the aspirating needle had already been performed without obtaining any liquid. A third puncture was performed in our presence, when about forty grammes (ten drachms) of blood were withdrawn from the joint. Dr. Labbe said he was glad he had repeated the punctures, as this quantity of blood lying in the joint would, as is always the case, have taken a long time to be absorbed, and also retarded the healing process. Compression had been employed with no effect. He referred to a similar case he had recently treated in private practice in which, after having made a small incision into the surface, he had withdrawn a large number of worm-like pieces of clotted blood. Healing had taken place rapidly.

In order to employ aspirating puncture with good results in cases of effused liquids in the knee, there should be at least two or three ounces of liquid in the joint. Puncture is made without reference to the patella, and where the tumour bulges most.—*Lancet*, Sept. 21, 1872.

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Disease of the Femur; Amputation at the Hip-joint; Recovery.—The following case is of considerable interest, inasmuch as it is one of necrosis of the shaft of a large bone occurring without any suppuration whatever. The history pointed to a malignant affection, but a most careful examination of the bone after removal failed to detect such a condition, and showed without doubt a necrosis. For the notes of the case we are indebted to Mr. Parnell, house-surgeon.

J. B., aged twenty-two, a thin, emaciated young man, was admitted into St. Bartholomew's Hospital, under the care of Mr. Morrant Baker, on August 13, with disease of the left femur. The history is as follows: Ten weeks before admission he went to bed quite well, but on waking in the morning he felt great pain in his left thigh; on the next day he noticed that the thigh was swollen. This went on increasing for six weeks, when, as the patient was walking in his room, the bone broke spontaneously, and he fell down; and since then he has been unable to walk. On admission the left thigh was greatly swollen, the swelling being due to increased thickness of the bone. At about the middle third the bone was angularly curved, the prominence being outwards and forwards; and there was an inch and a half of shortening.

The case being diagnosed as malignant disease, amputation at the hip-joint was performed on August 15. Chloroform being administered, an abdominal tourniquet was applied over the lower part of the aorta. Antero-posterior flaps were then made by transfixion, the posterior flap being several inches longer than the anterior one. The femoral vessels were compressed by an assistant seizing the anterior flap as the knife cut outwards. There was very little blood lost, but many ligatures were necessary to secure the bleeding vessels. The surfaces of the

flaps being washed with a carbolic acid solution, the wound was brought together by wire sutures, the ends of the ligatures hanging out at the extremity of the wound. Lastly, a large pad of lint soaked in carbolized olive oil was placed over the stump, which was then supported by means of a bandage.

On inspection of the removed limb, the muscles surrounding the bone were pale and appeared to be extensively infiltrated; the bone was thickened through the greater part of its extent, but markedly so at and below the seat of fracture, which was at the upper part of the middle third. On longitudinal section of the bone, the well-defined compact portion was seen to be surrounded by a firm casing about a quarter of an inch thick; here and there, however, the continuity of the compact tissue was interrupted. On a more careful examination made subsequently, it was found that the shaft of the bone was necrosed, and not the seat of malignant infiltration, as was at first supposed, and that the casing was made up of lymph thrown out by the periosteum and surrounding soft tissues.

Shortly after the operation, the patient was ordered fifteen drops of tincture of opium, with some brandy. In seven hours the temperature had gone up from 98.4° F. to 100°. On the day of the operation, and for the next two days, the patient was troubled with retching and vomiting.

Aug. 17. The wound was dressed for the first time. Temperature, 101°; pulse, 138.

20th. Wound suppurating freely. Temperature 104.4°; pulse 120.

23d. Fifteen ligatures came away, and on the 24th five more were removed. Temperature 100.2°.

From this date the temperature gradually descended to the normal, the appetite being good throughout.

Sept. 5. The wound is rapidly healing; the last ligature came away to-day.

The local treatment has been throughout the thorough sluicing of the interior of the stump with weak permanganate of potash lotion twice daily, by using a rubber tube, with an elastic catheter to be introduced within the wound attached to one end, as a syphon from a basin containing the lotion.—*Lancet*, Sept. 21, 1872.

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Ligature of the Common Carotid for Hemorrhage consequent on the Removal of a Maxillary Tumour.—H. R., aged 57, gardener, was admitted on May 20, 1872, into St. Thomas's Hospital, under the care of Mr. Le Gros Clark. The most noticeable symptoms in the history of the tumour were rapidity of growth and increase of pain. The pain, which was the first symptom, was not felt until three months before admission, and swelling of the hard palate and upper jaw were noticed a month afterwards. No other member of the family, so far as could be ascertained, had suffered from cancer.

On admission, the patient had a considerable tumour of the upper jaw, distorting the face and forcing its way into the mouth. The eye was partially closed, and there was a discharge from the left nostril, where a polypus was visible. The teeth had disappeared from the left superior maxilla, with the exception of the two incisors. No glandular enlargement of the neck was detected.

On introducing the finger into the mouth, the tumour was felt as a firm elastic mass, and scattered about it were some openings like pinholes. The patient's symptoms were such as might be expected from the character and position of the growth; severe shooting pain in the left side of the head, difficulty of swallowing, much thickening of the voice, and impairment of vision from the upward pressure of the floor of the orbit, so that objects above a certain elevation appeared double. A small portion of the interior of the growth was obtained by harpooning from one of the openings before referred to in the hard palate, and was found to consist of a fibrous nucleated stroma with cells, chiefly of an epithelial character; there were occasional myeloid forms, but a large proportion were very erratic.

On June 12, Mr. Le Gros Clark removed the left superior maxilla. The line of incision passed downward from the inner angle of the orbit by the side of the nose round the left ala nasi to the middle of the lip, and outward along the lower margin

of the orbit to the middle of the zygoma. The soft growth which was found filling the bone extended so far back that it was impracticable entirely to remove it. Vessels in the tumour under the masseter bled freely, and were twisted. The actual cautery was applied to the exposed surface, and the superior maxillary nerve cut short. A sponge, covered with gutta-percha tissue, was introduced to fill out the cheek, and the edges of the wound were accurately adapted with wire sutures.

June 14th.—The sponge was easily removed. The wound was cleaned with Condy's fluid and replugged with oiled lint.

June 17th.—The wound was syringed with Condy's fluid. The incision had healed throughout almost the entire length. All sutures were removed. 7 P.M.—There was copious hemorrhage—about twenty ounces. The bleeding was temporarily arrested by the application of ice and repeated pluggings of lint dipped in perchloride of iron. The condition of the patient, however, rendered it necessary that there should be some better security against hemorrhage, and accordingly, at about half-past ten o'clock, Mr. Wagstaffe tied the common carotid artery. An incision, between two and three inches in length, was made over the edge of the sterno-mastoid muscle, the skin and fascia were divided, and the superficial veins twisted. The artery, which was large, emerged from under the sterno-mastoid at about a level with the upper border of the thyroid. A double catgut ligature was used and cut short. The wound was brought together with strips of plaster. The plugs were then removed from the mouth.

June 18th, 6 P.M.—The pulse was small, and the face much blanched. The patient's general condition was somewhat better than was expected. Since the operation the patient had slept a little, and had taken custard milk and iced brandy and water with some relish.

June 20th, 6 P.M.—He had been very restless, and had taken but little nourishment.

June 21st, 6 Evening.—The patient remained in the same state until noon to-day, after which he sank rather rapidly and died at about half-past five o'clock. There was no noticeable return of pulsation in the temporal artery. A *post-mortem* examination was made by Dr. Payne about twenty-one hours after death. A mass of new growth or inflammatory material remained attached to the under surface of the floor of the orbit, and a small abscess was found under the zygomatic process. Besides this, there was no pus. The left side of the neck was also examined, and the vein and nerves (pneumogastric and descendens noni) were found uninjured. There was very little pus also in this wound. The upper lobes of both lungs were found studded with grouped patches of gray tubercle, and some masses of fibroid tissue, but no caseous matter. The lower lobes contained also scattered gray tubercle. The bronchi were inflamed, and the bronchial glands were large, hyperæmic, and succulent, but not caseous. The liver, spleen, and kidneys were healthy. The brain also was healthy. The arteries of the circle of Willis contained the ordinary *post-mortem* clots, and a similar clot was found in the upper part of the internal carotid.—*Brit. Med. Journ.*, Sept. 21, 1872.

Eight Fistulæ in Ano, with Stricture four inches up Rectum.—A patient in King's College Hospital under the care of Mr. Henry Smith exhibited the most deplorable condition of the rectum, the buttocks being riddled with fistulæ, open and healed up. Five distinct fistulæ opened on the left buttock and three on the right, and a number had spontaneously healed up. They all opened into, or nearly into, the rectum at and above the stricture. The patient was a soldier, in excellent health otherwise, strong and robust, and he had been twice operated upon by qualified surgeons; but they and the physicians who had seen him had failed to detect the stricture. It was just beyond the reach of the finger, and was therefore overlooked. Mr. Smith demonstrated the stricture by introducing a No. 10 catheter, which could only pass up with difficulty; under chloroform it passed

easily, but no more. When the stricture was freely divided, a No. 1 rectal bougie passed up readily six inches. Mr. Smith then freely divided the fistulæ also, although some of them opened fully two inches from the anus, making long cuts into the bowel and laying the anus quite open. The remains of former operations, in the shape of thickened skin about the anus, he then removed with scissors; and, after stuffing with sponges and padding, the man was removed. The operator remarked, that, when stricture exists with fistulæ, it is quite impossible to cure the latter without dividing the former. So long as the stricture exists, so long will the fistulæ open on the buttock; and the stricture should in every case be looked upon as the primary disease. In some few cases a necrosed coccyx or sacrum is the cause of the fistulæ, and requires primary attention; but generally it is stricture. Mr. Smith also noticed the precise parallel between fistulous openings in the perineum and stricture of the urethra, and such cases as he had just operated on.—*Ibid.*

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

On Chloral in Pertussis, and a Poultice of Digitalis in Suppression of Urine and in Puerperal Convulsions. By G. R. Henry, M.D., of Burlington, Iowa.

I have used the hydrate of chloral now for two years, and have not met or heard of a case of whooping-cough that was not promptly *cured*. I have suggested its use to a number of practitioners, who all report a perfect success. It will control the spasmodic cough, if given in the latter stages; and, if given early, it will prevent the whoop from appearing. I use it dissolved in syrup of Tolu, in doses of two to ten grains, according to age of child, and repeated as often as the cough occurs; and I have yet to see a case that required more than ten days' treatment. Contrast this with the weeks and months of suffering and distress which we have seen wear out our little patients.

Another remedy, which has not the position given to it to which it is entitled, is a digitalis poultice, applied to the abdomen in cases of *urinal suppressio*.

I have used it with marked success in cases of puerperal convulsions, and in other cases where the stomach would not tolerate remedies by the mouth. I have seen it fail, in common with all other remedies, in some cases of fever, where the suppression was due to a loss of vital action in all the organs; but I have also had such decided and marked good results from its use, that I think it worthy of more notice than it receives from the profession.

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Case of Abscess of the Cervix Uteri.—By W. Scott Hill, M.D., of Augusta, Maine. In November, 1868, Mrs. A. G., age 43, mother of seven children, consulted me for menorrhagia of sixteen months' standing. The patient was rather above the ordinary size and very anæmic. The last confinement was some three years previous to the above date. She had been prescribed for by a physician, but no examination made. Complains of some pain in the pelvic region, but not enough to prevent her from doing her ordinary work or from walking or riding. Has some leucorrhœa. Examination with speculum showed a large cavity on the right lateral aspect of the cervix uteri, about six lines in diameter at its outer surface, and apparently about three at its entrance into the cervical canal. The cervix was considerably enlarged, about one and three-quarter inches in length, by one and one-half in diameter. The anterior and posterior lips were soft and patulous, having much the appearance on the surface of a ripe strawberry. The treatment was principally by local applications of tr. iodine, with injections of chlorate of potash. For the menorrhagia, some of the preparations of opium, with gallic acid in ten grain doses, and occasionally acetate of lead, afterwards ferruginous tonics. The cavity gradually filled with healthy tissue. The cervix resumed its normal size in the course of a year. She is now in her usual good health, and menstruates regularly though past 46 years of age. Nothing could be learned from her history of the

case to show how long the above condition had existed when first seen by me.

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Remarkable Inaction of Strychnia administered Hypodermically.—Dr. Thomas Kennard states (*Medical Archives*, June, 1872) that on the 5th February he commenced the hypodermic injection of strychnia with a patient "whom I believed was suffering from white atrophy of the optic nerve, and who had no vision from one eye, and very imperfect from the other for several years, and for which trouble every means which promised good had been tried in vain. I was naturally timid in my first experiments with so powerful a remedy, and began with the $\frac{1}{60}$th of a grain, which, having no perceptible effect, I then increased day by day, to the $\frac{1}{40}$th, $\frac{1}{30}$th, $\frac{1}{24}$th, $\frac{1}{15}$th, $\frac{1}{12}$th, without perceiving any benefit or effect whatever. I then, on the 7th day of treatment, used the $\frac{1}{12}$th, morning and evening, for some five days, when I combined with it the elixir quiniæ et strychniæ ferrat ʒij, or the $\frac{1}{30}$th of a grain of strychnia three times a day, and still perceiving no effect from this heroic treatment, except slight twitching on one occasion, I began to consider my patient strychnia proof, and ventured to increase the hypodermic dose, on the 14th day, to the $\frac{1}{8}$th, then to the $\frac{1}{6}$th, $\frac{1}{5}$th, and even the $\frac{1}{4}$th, without any perceptible effect, more than I expected from the tonic influence of the elixir taken internally. This patient was a delicate and infirm man, about fifty years of age. Whilst he was under treatment, I used hypodermically the same remedy—only increasing the amount injected more rapidly—with a young woman who, within a short space of time, had lost completely the senses of smell, taste, and vision; but was apparently otherwise in the enjoyment of perfect health. I commenced with her on the 13th of February with the $\frac{1}{24}$th gr., then day by day I increased to the $\frac{1}{15}$th, $\frac{1}{10}$th, $\frac{1}{8}$th, until the sixth day, I injected the $\frac{1}{6}$th, and repeated that dose five days without any perceptible effect whatever, except upon the third or fourth day, when she had some twitching, and her vision was improved slightly, or rather she thought that she could distinguish light from darkness, and perceive large bodies passing her, which she could not do before. She was also taking the elixir internally, $\frac{1}{30}$th of a grain of strychniæ three times a day. This improvement was only transient, however.

"On the 17th of March I was called to see an Irish woman, who for seven or eight months had been suffering with partial paralysis of the arm and leg of the right side, accompanied by a most intolerable feeling of coldness, as if ice was packed on that side. I commenced with the $\frac{1}{24}$th of a grain of strychnia hypodermically, and the elixir of quinia, iron, and strychnia ʒij internally three times a day, and gradually increased it to the $\frac{1}{12}$th, $\frac{1}{8}$th, and the $\frac{1}{6}$th, which dose I continued until the 27th without any toxical effect whatever. Her limb soon got naturally warm, but most likely from the effects of the strong veratria ointment which I rubbed it with; though, perhaps, the strychnia produced it, as Echeverria recommends it very highly in such cases, and reports several cases thus treated satisfactorily.

On the 1st, 2d, 4th, and 5th of April I injected the $\frac{1}{12}$th, $\frac{1}{8}$th, $\frac{1}{6}$th, and $\frac{1}{5}$th of a grain of strychnia into the arm of an old lady seventy-two years of age, for partial paralysis, with some benefit, but no poisonous effects whatever; there was not the slightest twitching produced in her at any time, and I had employed it with her on one former occasion with the same result.

Such has been my short experience with the hypodermic injection of this powerful remedy, and it differed so materially from the published reports of others, that I thought it worth while to make a note of it; for, although authorities have varied in regard to the dose of strychnia to be administered hypodermically, and Courty and Eulenberg have injected as much as the $\frac{1}{3}$th of a grain, the majority have recommended from $\frac{1}{60}$th to the $\frac{1}{24}$th of a grain, and cautioned us against the dangers of even the latter amount; and, so far as I know, none before me have doubted that it would produce its usual physiological and toxic effects when injected beneath the skin.

Death from Ether.—Dr. W. B. Dunning, Acting House Surgeon at the Bellevue Hospital, New York, reports (*Medical Record*, Oct. 1, 1872) the case of J. S., a saddler, aged 68, who was admitted into the Hospital on August 2, 1872, suffering from a fracture of the left femur, just below the trochanter. The patient was treated by a "Buck's extension" until Aug. 20, when it was decided to apply a plaster of Paris splint. In order to make sufficient extension, and at the same time prevent the pain of the operation, ether was ordered to be administered. The administration of the anæsthetic was slowly and carefully made, and after perhaps ten minutes the patient was fully under its influence and the operation begun. A few turns of the plaster had been made, when the patient's breathing was observed to be rather frequent and gasping. The pulse was, however, full and regular. The thorax was compressed two or three times, and the patient's breathing again became normal. As these symptoms not rarely occur during etherization, they excited no special alarm. The ether was, however, withheld from the patient four or five minutes, his repiration and pulse being normal. As he then began, however, to move about and his muscles were becoming rigid, the ether cone was again applied. In a minute or two, the assistant, who was giving the ether, observed the pupils to be dilating rapidly and the breathing to cease. His heart was still beating, however. The ether cone was of course immediately removed and artificial respiration was again used, and all the batteries obtainable in the hospital were put in operation in an effort to resuscitate the patient. His muscles occasionally responded by a spasmodic movement, but no breathing again occurred. The efforts at resuscitation were continued about forty minutes, until all response to the action of the battery had ceased.

Autopsy was made three hours after death. Rigor mortis was marked. Blood was fluid. Heart contained a little fluid blood with a little atheroma at base of aortic valves. The lower lobe of right lung is œdematous, and its lower portion in a state of red hepatization.

Ether was pure, and about ℥vi was used.

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Naval Medical Board.—A Board consisting of Medical Director Charles D. Maxwell, President, Medical Director William Greer, Medical Inspector Thos. J. Turner, Surgeon Albert L. Gihon and R. C. Dean members, and Surgeon Joseph Hugg, Recorder, has been convened at Washington, D. C., for the examination of candidates for promotion and for admission in the medical corps of the navy.

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The University Hospital, Philadelphia.—Ground was broken on the 12th of October, for the erection of this Hospital on the lot bounded by Spruce and Pine Streets, and by 34th and 36th Streets, containing about eight acres. This lot was granted by the City of Philadelphia to the Trustees of the University of Pennsylvania for the erection thereon of the University Hospital. T. W. Richards, Esq., the University architect, has been entrusted with the drawing up of the plans for the building.

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The German Hospital.—The new building of the German Hospital Association, at Corinthian and Girard Avenues, Philadelphia, has been put in complete order, and is now open for the reception of patients. It has at present room for seventy beds and its capacity is to be increased soon. All the patients from the old building have been transferred to the new one.

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Vital Statistics of the United States.—Dr. J. M. Toner, of Washington, from an examination of the census returns, asserts that the American people are showing unmistakable signs of physical degeneracy.

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Dr. Brown-Sequard has resigned the chair of Comparative and Experimental Pathology in the Faculty of Medicine in Paris, which he has occupied for several years. Dr. Brown-Séquard will hereafter reside in the city of New York.

FOREIGN INTELLIGENCE.

Brasdor's Operation in Innominate Aneurism.—Mr. Timothy Holmes, Surgeon to St. George's Hospital, in one of his "Lec-

tures on the Surgical Treatment of Aneurism in its Various Forms," gives (*Lancet*, Aug. 31, 1872) the following conclusions on the subject of Brasdor's operation in innominate aneurism, which appear to him to be justified by present experience.

1. That the distal ligature of the carotid alone, or in conjunction with that of the third part of the subclavian, cannot be trusted to produce the complete consolidation of the tumour.

2. That, however, the natural effect of the ligature of the carotid artery is to produce coagulation in the part of the sac directly connected with the mouth of that artery.

3. That this may suffice practically for the cure of the aneurism, when the subclavian portion of the sac is small and shows no disposition to grow.

4. That in other cases, where the mouth of the subclavian artery is previously obliterated by impacted clot, the ligature of the carotid only may effect a radical cure.

5. That for these reasons it is better, in any case which appears to require distal ligature, to commence with the operation on the carotid alone, and afterwards to consider the propriety of securing the subclavian either in its first or third part.

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Quadruple Amputation.—In the autumn of 1869, Dr. Begg, of Dundee, amputated the whole of the extremities in the case of a young woman named Robertson, whose hands and feet had assumed a gangrenous condition, the proximate cause of which was attributed to embolism. After the operation a subscription was raised, and the poor woman sent to London, where, at the request of some influential friends of hers, Mr. Heather Bigg had constructed for her some especially devised prothetic appliances, in which the distinguishing features were, that the artificial hands were automatic in action, opening and shutting their fingers at the will of the patient. This peculiar prehensility gave her the power of grasping even so small a substance as a crochet-needle, and enabled her to gain a comparatively lucrative livelihood by making shawls, etc. So admirably did she do this, that one was sent by her to the Queen, who, struck by the excellence of the workmanship and the remarkable means by which it was accomplished, generously gave the poor woman £5. The artificial legs were also so arranged as to enable her to stand and walk with the aid of crutches. Three years have passed since she first began the use of extraneous appliances, and she now writes an admirable hand, besides knitting, feeding, and dressing herself, etc. In a communication made by her a few days since, which is now before us, she writes that she can walk alone quite easily with the aid of crutches, and that no one could observe the cause of her lameness. The case is one of no common interest, owing to its being the only one on record in which the whole of the four extremities have been removed. Apart from its pathological value, as indicating how life may be saved by judicious interference in cases of embolic gangrene, there remains the gratifying result that, by the use of ingenious mechanism, the patient is enabled to gain her living, whilst presenting nearly the same external appearance as if she still retained possession of her natural limbs. It is an unique case, and a triumphant instance of mechanical ingenuity.—*Brit. Med. Journ.*, Oct. 5, 1872.

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Treatment of Fracture of the Leg with Lateral Distortion.—Mr. Henry Taylor describes the following mode of treatment for this accident, which he observed practised in the Copenhagen Hospital. "Some cases," he states, "of fracture of the leg were put up in a splint of peculiar construction, devised by Professor Stein of this city, which appeared to act efficiently in cases attended with lateral distortion, as in Pott's fracture. The apparatus consists of a wooden fracture-box, of greater width than the leg, having a sliding foot-board and three binding screws in each side-piece, which can be made to press against the sides of the limb at its centre and both extremities. Small hollow side-splints are first applied to the leg, and receive the pressure from the screws, which are tightened at the points most requiring it. This application of

pressure, acting from points unconnected with the limb, nearly resembles the action of the surgeon's hands in rectifying displacements, and is not effected by any other splint with which I am acquainted." —*Brit. Med. Journ.*, Sept. 28, 1872.

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Sciatic Hernia.—Dr. Marzolo, of Padua, has related the case of a woman who first came under notice in 1847, at the age of 30. Ten years previously she had observed a small swelling in the left buttock; it disappeared when she lay down, but reappeared in the erect position and gradually increased. She had four abortions, and bore one healthy child. When seen, the hernia extended over part of the buttock, as far as the trochanter, and forward to the groin. The abdominal wall was retracted. On lying down or sitting, the greater part of the contents of the swelling could be returned into the abdomen; defecation and coition were difficult. Last year the patient again came under observation. Her condition had changed but little; but the hernia was now irreducible, and at the lower part there were dulness on percussion and fluctuation. A puncture was made, and nine litres of fluid removed. Diarrhœa set in and the patient soon died. No post-mortem examination could be obtained.—*Brit. Med. Journ.*, Oct. 5, 1872.

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Spina-Bifida cured by repeated Punctures and Compression.—Dr. Camara Cabral exhibited to the Lisbon Academy of Medical Sciences (Feb. 17th) an infant of four months of age, whom he had cured of congenital spina-bifida by the above treatment. The punctures were made with the "aspirateur" of Dieulefoy, and 305 grammes of albuminous fluid withdrawn by six operations performed at intervals. Compression was made by adhesive bandages.—*O Corrieo Medico de Lisboa.*

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Skin-grafting.—M. Marduel has given in the *Lyon Médical* (for September 15 and preceding numbers) an elaborate analysis of all the hitherto published facts connected with this subject, which will prove of great use to all those investigating it. In regard to the "clinical results" which may be fairly deducible from the trials of the practice, he speaks much less sanguinely than many of those who have adopted it. It is true that the graftings seem often to have increased the rapidity with which cicatrization takes place; but then this is especially observed in those wounds which have a red, healthy appearance, and seem (as Reverdin says) as if about to cicatrize; but when we have to do with atonic, fungous, and soft granulations, the means fail, as they do in scrofulous wounds and all others that have no tendency to cicatrize. Some surgeons, indeed, ask whether the true cause of the more rapid cicatrization when it does take place is not rather the minute care which is taken in dressing the wound. Then, again, the solidity of the cicatrix has not always proved considerable, ulceration in it readily occurring. In fact, the success of skin-grafting, amidst so much contradictory evidence, cannot yet be considered as established, and further investigation into all the circumstances attending the practice is called for.—*Med. Times and Gaz.*, Sept. 28, 1872.

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Rupture of the Uterus and Successful Gastrotomy.—Dr. Fourrier, of Compiégne, relates in the *Bull. de Thèrapeutique* for August 15, in great detail, one of the most remarkable cases on record. We have only space to note the chief points. He was called on December 18, 1871, to a woman, 29 years of age, in whom on the 14th rupture of the uterus had taken place, with discharge of the child (between seven and eight months) into the cavity of the abdomen. The woman was apparently sinking from exhaustion, and after putting her under chloroform gastrotomy was performed. The child, together with the placenta and membranes, having been removed, the left iliac fossa was found to be lined with a blackish membrane in shreds, which was afterwards determined to be the peritoneum in a state of gangrene. Coagula concealed the aperture in the uterus, but neither after the accident nor during the operation had there been hemorrhage of any importance. The case went on well,

with some fluctuations, until January 14, when enteritis and what was at first feared to be purulent infection set in. Quinia was given in large doses with good effect, and the patient eventually did well. By February 19 she was considered quite well, and in May menstruation reappeared. She has been seen several times since, and continues quite well.—*Med. Times and Gaz.*, Sept. 21, 1872.

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Treatment of Poisoning with Atropia by Morphia.—M. Abeille communicated a case to the Academy of Medicine (*Bullet. de l'Acad.*, Aug. 27) in which symptoms of poisoning induced by the hypodermic injection of nine milligrammes of atropia were treated and cured by the injection of thirty-seven milligrammes of the hydrochlorate of morphia, without any other means (not even sinapisms) being had recourse to. It was a case of sciatica, which during four months had resisted all means of treatment, including morphia injections. Having in similar cases obtained successful results from atropia, M. Abeille resolved on its use, notwithstanding its well-known danger, being satisfied that he could meet this by means of morphia. This conviction was the result of its use in a case of very dangerous poisoning related to the Academy in 1868. In the present case the cure was complete, for it has continued during two years, and the symptoms of poisoning were dissipated within three-quarters of an hour by one injection of morphia.—*Med. Times and Gaz.*, Sept. 21, 1872.

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Use of Milk in Cancer of Stomach.—The invaluable benefit of milk diet in cases of cancer of the stomach has been forcibly brought out in an instance recorded by the *France Médicale* for August 24. The patient, under the care of Dr. Siredey, at the Hôpital la Riboisiére, had not been able for two months to take any kind of food without immediately throwing it up. Milk, in small quantities at first, was then ordered as diet. It was not brought up, and consequently during thirty-six days it was used in any quantities, and without inducing sickness. At the end of this time other sorts of food were given, and properly retained.—*Lancet*, August 31, 1872.

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Linimentum Calcis in the Treatment of Surgical Cases.—Mr. R. T. Manson states (*Brit. Med. Jour.*, Oct. 5), that he has tried the linimentum calcis in a great variety of surgical cases, from bruised fingers to amputations, and with uniform success. The advantages of its use are: lessening the secretion of pus from a wound; easiness of application; extreme adaptability to irregular surfaces; prevention of the access of atmospheric air to the wound; promotion of healing by first intention, or, when that does not occur, promotion of healthy granulation; doing away with the use of nitrate of silver or sulphate of copper; ease to the patient; and saving of time to the surgeon. Used on lint, the linimentum calcis is not nearly so valuable as when used on fine cotton-wool. Lint does not get into the holes and corners of an irregular wound as cotton-wool does; it is not removed so easily; it becomes more easily dried and hardened, and possesses less of the nature of an artificial skin than cotton-wool. Linimentum calcis has long been used for burns and scalds. Some surgeons think it a nasty application; but, when made with olive-oil instead of linseed-oil, as was formerly the case, the nastiness is abolished. The *modus applicandi* is as follows: On a piece of fine cotton-wool, rather larger than the surface of the wound to which it is to be applied, the linimentum calcis is poured and spread over the wool, which is then placed over the wound and covered with common wadding. Either bandages or strips of plaster may be used to keep the lint in position.

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Mercury in Syphilis.—The employment of mercury in syphilis has been again lately much discussed. We (*Gazette des Hôpitaux*) have witnessed the practice of both the supporters and its denouncers. To us, it is beyond doubt that mercurial preparations, properly administered, shorten the duration not only of the secondary accidents, but even of the tertia-

ry, which have resisted iodide of potassium administered alone. As to the choice of the mode of application, Sédillot's pills have appeared to us as efficacious and more agreeable to take than bichloride or the hydrargyric iodides. We know that each of these pills contains double mercurial ointment, 10 *centigrammes;* medicinal soap, 10 *centigrammes;* marshmallow powder, 10 *centigrammes.* They are daily prescribed by M. Richet, M. Hardy, and others. By giving these concurrently with iodide of potassium, and disusing them from time to time, so that they can be alternated with a draught containing chlorate and nitrate of potash, they can be continued for months without producing either salivation or fatigue of the digestive canals. This is an excellent plan of treatment when one is anxious that certain accidents menacing existence, such as intracranial tumour, should rapidly disappear; but it must not be forgotten that, if these tumours manifest themselves by epileptiform attacks alternating with coma, returning at very short intervals, this specific treatment must not then be commenced. These symptoms must first be subdued by acting on the excitability of the brain. Tincture of amber in large doses, and bromide of potassium, of which the action is slower and more lasting, conduce to this result. Thus the system can for the time be reduced to calmness, although the tumour still exists. Things go on the same as before the first epileptiform attack. The morbid growth is still there; its pressure is always the same; but the brain is quiet. This truce must be taken advantage of, to at once administer the mercury and iodide. Expective treatment is not admissible in such a case.—*Ibid.*

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Syphilization.—Mr. Henry Taylor, in his notes of observations made in the hospitals of Christiania and Copenhagen (*Brit. Med. Journal*, Sept. 28, 1872), states that, "In the Royal Hospital at Christiania, I had the good fortune to find Dr. W. Boeck going round, who took the trouble to explain to me, in my own language, the nature of the more important cases under his care. The practice of syphilization, which has had so zealous an advocate in that distinguished physician, is still pursued by him exclusively in all forms of constitutional syphilis, and was being carried out in a great number of the cases before me; and, as I was told, with unvarying success. His plan is to inoculate the patient in the first instance with virus from a fresh sore, and then to continue the inoculation every third day with discharge from the sores thus artificially produced, until it ceases to have any effect, when the cure is considered complete, the constitutional symptoms having disappeared *pari passu*. The parts selected for inoculation are the chest and abdomen, and the operation is performed with a large lancet, which, after being charged with his virus, is placed vertically with its point on the skin, and twirled round so as just to penetrate the cuticle; the point is then wiped on the puncture. As two or three punctures are made every time, and as the treatment may extend over a period of several months, it follows that the patient's trunk is sometimes diapered all over with cicatrices, as happened in more than one instance among those in the hospital. In one man the resulting sores had an ugly aspect from phagedænic ulceration, but in the great majority no undue action had followed, and the constitutional symptoms had certainly declined or disappeared altogether, whether from the influence of syphilization, or from the natural cure effected by time, it would be hard to decide. As no other treatment, local or general, is allowed, except the light application of nitrate of silver to ulcers, the inoculation plan is credited with the cures. Notwithstanding this apparent success of syphilization in Dr. Boeck's hands, it is not practised by any of his colleagues in the hospital, nor by the profession in general. The objection I heard made to it was that it was 'too cruel.'"

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On the Combination of Chloroform and Morphia.—At a recent meeting of the Académie des Sciences, M. Demarquay read a paper on the practice of combining the subcutaneous injection of morphia with the administration of chloroform,

which has on several occasions been put into force in consequence of M. Claude Bernard's experiments having shown that in this way the anæsthetic condition can be kept up by the employment of a much less quantity of chloroform. According to M. Demarquay's own clinical observation, as well as the results of his experiments on animals, this practice, so far from diminishing, may add to the dangers of chloroform, especially when the patient is already in a depressed condition from hemorrhage, shock, etc. He observes that either of these agents administered separately produces a depression of temperature; and by using the two together he has lowered this by 2½° C. He is of opinion that the combination should be entirely renounced, and that all our efforts should be directed towards perfecting the administration of chloroform. He thinks that flannel is the best material through which it can be given, and has devised a mask made of it upon which the chloroform is allowed to flow from a bottle drop by drop. The evaporation is continuous, and the patient breathes without any effort, frequently falling quietly asleep without prior agitation. This apparatus, he says, has been employed by a great number of practitioners with excellent effect. He has stated his views upon the subject at length in the *Gazette des Hôpitaux* for August and September.—*Med. Times and Gaz.*, Sept. 21, 1872.

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Internal Use of Carbolic Acid.—Now that this acid is being tried internally, we should ascertain in what doses it may be poisonous. MM. Paul Bert and Jolyet, of Paris, have undertaken experiments to make out this point. Between forty-five and sixty grains will kill a dog of large size; nor should it be concluded that man could bear a dose in proportion to his weight compared to that of the dog, as thirty grains of hydrochlorate of mophia have been injected into the jugular vein of a dog without killing him. Of course one-fourth of this dose would kill a man. The above-mentioned authors state that carbolic acid is a powerful poison, which, very imprudently, is left in the hands of any body, either in solution or in the solid state. The former is the most dangerous, as some weak solutions for internal use are sold, as well as very strong ones intended for external use. Thus mistakes may easily occur. MM. Bert and Jolyet find that carbolic acid acts like strychnia on the excitability of the spinal marrow. It increases its sensibility, like strychnia, at first; but it diminishes that sensibility, or completely abolishes it, when the convulsive stage has exhausted the medulla. The phenomena resulting from carbolic acid are said by our authors to be quite similar to those produced by chloroform, chloral, ether, woorara, and the section of a motor nerve.—*Lancet*, July 13, 1872.

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Antidote to Carbolic Acid. — Various oily substances have been recommended as antidotes to carbolic acid poisoning. Dr. Husseman (*Pharmaceutische Zeitschrift für Russlande*) finds saccharate of lime the most effectual.—*Brit. Med. Journ.*, Oct. 5, 1872.

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Deaths from Chloroform.—In the *Brit. Med. Journ.* for Sept. 28, 1872, it is stated that a girl, æt. 16, expired at the South London Ophthalmic Hospital, while under the influence of chloroform administered preparatory to an operation on the eye.

In the No. for Oct. 5, of the same journal, there are reported two more cases of death from chloroform. One occurred in a lady aged over 70, who fell down stairs and fractured her leg into the knee-joint. Chloroform was employed to aid in the reduction. "The patient quickly succumbed to its influence, death ensuing, when very little chloroform had been used. We are not aware that any autopsy was made."

The second case occurred in the London Hospital. A publican, aged 34, had suffered for some time from inflammation of the foot and leg, probably connected with disease of bone. A sinus passed from the outer side of the foot, near the malleolus, under the sole of the foot; but, having no dependent opening, pus was collecting in it continually. It was proposed to examine further into the condition of the parts, and make a free escape for the pus. The patient begged that

chloroform might be given him: this was accordingly done by the house-surgeon, another gentleman taking charge of the pulse, and the surgeon proceeding with the examination. The man exhibited no peculiar symptoms at all at first. He passed through a very feeble "excitement stage," and he was never fully under the influence of the anæsthetic, for, on touching the ocular conjunctivæ, he always displayed the usual reflex contractions of the eyelids. About three drachms of chloroform having been administered, the patient was considered sufficiently, though not entirely, under its influence to commence the examination, and no more of the anæsthetic was given, as the patient exhibited no signs of pain. No severe hemorrhage occurred, but the granulating wounds bled freely when enlarged. The administration had been discontinued for a minute or two longer, when the patient seemed to flinch; at the same moment the gentleman who had charge of the pulse said, "He has lost his pulse." No pallor of the lips nor peculiarity of respiration were at this moment at all visible: the chloroformist could hardly believe such was the case; but in a few seconds the patient began to sigh, and pallor, yet with some lividity, was observed. Artificial respiration (Silvester's method), galvanism to the heart, frictions, and brandy enemata, were in immediate use; but, after about three-quarters of an hour, the air entering the chest became practically nothing, and all hopes were abandoned. It should be mentioned that the viscera of the chest had been previously examined, but there were no physical signs to enable one to discover any disease whatever in the heart or lungs.

A post-mortem revealed that the heart weighed 11¾ ounces; the cavities were natural. The muscle of the left ventricle was somewhat paler and softer than natural; but this change was no more than what is commonly seen after death from many causes: it was of natural thickness; there were no transverse yellow markings to indicate fatty degeneration. Under the microscope, the muscular fibres were seen to be somewhat degenerated; they were granular, and the transverse striæ were more feebly marked than in healthy muscle of the heart. The valves and orifices were healthy. The left ventricle was not firmly contracted, though slightly so, and it contained some fluid blood.

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The Fate of the Leporides.—Most biologists, and especially the readers of Darwin, will remember that, in 1868, M. Eugene Gayot, of Bretigny-sur-Orge, obtained, by crossing a hare with a rabbit, a mongrel, to which he gave the name of *leporide*. This animal became fertile, and the hope was entertained that a new species of animal would arise for domestic use; but this hope was deceived, and quite recently M. A. Sanson has made an interesting communication to the Academy of Sciences on the subject. Mated together, these hybrids of M. Gayot became fertile, and their fertility did not seem to be weakened; but they were simply hybrids, which, as others have done, oscillated for a time between the two types from which they descended, before returning definitely to one or other of these types. From the experiments of M. Gayot, he found that the greater number of his leporides returned decidedly and rapidly to the rabbit type, whilst only a few, and, with difficulty, tended towards the hare type. As to the fertility of these hybrids, it explains itself, according to M. Sanson, by the vicinity of the two species in the common race. The species are disposed in regular series. Those which are vicine in their series produce, by interbreeding, offspring which are fertile. It is still the same when they are not too far removed. If there be between them more than a certain number of series, the offspring of their breeding is sterile.—*Brit. Med. Journ.*, Oct. 5, 1872.

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Smallpox in the German Army.—The total number of deaths from smallpox in the German army, during the recent war, was only 203. This small mortality is attributed to the system of compulsory vaccination which every man who enters the army must undergo.—*Med. T. and Gaz.*, Oct. 5, 1872.

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Strangulated Hernia. Delivered at St. Bartholomew's Hospital. By Sir James PAGET, Bart., V. P. R. S., Consulting Surgeon to the Hospital. (Continued from p. 191.)

LECTURE IV.—The former lectures have related to the diagnosis of strangulation of a hernia, and to the operation necessary for its relief. This last will be on the treatment of cases after operation. In looking over my cases of hernia for illustration of this matter of after-treatment, I was struck with the great difference between the practice of late years and that of thirty or more years ago. In reference to all the subjects of the preceding lectures—the discrimination of the cases needing operation, the modes of operating, and generally the pathology of strangulated hernia—knowledge has, we may believe, increased, but without any material change of opinion; but, when we come to questions about treatment of patients after operation, we seem to know, and certainly we believe, things widely different from those which were generally believed when I was a student.

The present general rule of practice after operation, in cases likely to go on well, is to do what is called nothing; to wait till some reason for interference is manifest; and, while waiting, to take care that the patient shall have fit bedding, fit air, fit food, quietude, and good nursing. All these prime conditions of health are

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called "nothing." The contrasted "something" would be bleeding, active purging, or other restless interference with the natural course of recovery, such as was in vogue in the earlier years of my case-taking, and such as had not quite ceased twenty-five years ago, when I became assistant-surgeon to the hospital. In this contrast you will see only an illustration of the great change of opinion respecting treatment which may be observed in a wide range of medical practice, as in cases of fever, acute rheumatism, pneumonia, and all acute inflammations—a change shown, not by substituting one remedy for another, but by letting many diseases and the effects of many injuries take their natural course, in the confidence that they will come to a natural good end, and that we have no medicines potent to alleviate or cure them. But let me say that, while I have no doubt that the present general plans of treatment are better than the past, I yet do not believe that the past plans were so mischievous as some have told of them. I have no recollection of serious harm being often done by bleeding in the many cases of illness, whether slight or severe, in which during my apprenticeship, I practised it. In a few cases I think it was mischievous, but in the great majority it was harmless. In many, it gave such relief from pain or other distress as naturally strengthened the belief that it did real good; and in a few cases I do not doubt that it was beneficial. Still, in cases of strangulated hernia, whether before or after operation, I think you never need bleed a patient. I do not believe that bleeding ever saved the life of a hernia-patient, which but for the bleeding would have been lost.

And as for purgatives, though I believe they were often mischievous and more often unnecessary, yet I do not doubt that they were, and still may be sometimes, very useful; and I wish I could tell you more exactly than I can the class of cases in which they should be used. At present I know only one—the class, namely, in which it is clear that the strangulation has occurred while the bowels are overfilled, and in which the strangulation is acute and quickly relieved.

Now for general rules of treatment after operations for strangulated hernia. Bear in mind the complicated cases with which you may have to deal. In each case there are, or may be, these constituents: the intestine damaged by displacement and by being forcibly replaced; the operation-wound; the effects of chloroform; the intestinal disorders which at least in many cases, preceded the strangulation, and may continue after the operation; the effects of aperients and other medicines given for this previous disorder or for the strangulation; the inflammation or worse than inflammation of the sac and its contents, which does not subside immediately after even a successful operation.

When a case has been timely operated on, all these things may amount to nothing worse than may be left to the course of spontaneous recovery; and a case that goes on well requires that "nothing" in the way of treatment of which I spoke just now. But when anything goes amiss, you must have in mind all the things I have enumerated, in your endeavour to interpret the signs of wrong and to amend it. Very few cases are more difficult to manage than those which do not go on well after operation for hernia. There are terribly few which, having gone out of the right course of recovery, can be brought back to it.

What, now, are the signs of going on well? Chiefly a consciousness of complete relief; that is, not only of relief from the local distress, but from the general misery. Deceptive as sensations often are, this rarely is, and, if a patient be not conscious of relief, you must keep on the alert, and suspect that something is wrong. Besides, there should be no pain or acute fever. Mild traumatic fever there may be; but there should be no more: no nausea or sickness, but general quietude or sound sleep, a gradual recovery of appetite and strength, and, after a time, action of the bowels. I say after a time, wishing to be indefinite. Sometimes the bowels act very soon after the operation, and this may be harmless; but I think it is not good, for it indicates either the effect of physic wrongly given before the operation, or some irritation of the bowels

which would be better at rest. They do best who, while relieved from their distress, have no action of the bowels for some days. I know no necessary limit to the quietude in which the bowels may be left. In one of my cases, they did not act for nine days after the operation; and I have heard of others where, without any disadvantage or discomfort, there was still longer inaction. But this is, I think, a good general rule—to leave the bowels at rest for four days after the operation; then, if all seem well (not otherwise), to order a simple enema; and, if this be not sufficient, some aperient. I know no advantage in leaving the bowels longer inactive than these four days; and I had one case in which great inconvenience, to say the least, was occasioned by a very large accumulation.

After the action of the bowels, if all still go on well, there is no need of considering anything but the patient's comfort and the local treatment, and the diet may be of the plainest kind. Excess is more likely to be mischievous than spareness.

Among cases that do not go on well, there is a great variety; but I shall speak of those alone in which the wrong is in something peculiar to hernia. Of course the wound of the operation may lead to any of the evils that may follow other wounds, as erysipelas, pyæmia, and the rest; but these I shall almost pass by.

Among my cases I find some in which ill-looking symptoms, such as diarrhœa or colic, followed the operation, but meant no serious mischief, being only the continuation of the intestinal disturbance which preceded the strangulation. I have already spoken of this matter, but it is worth repeating: that it is common for the descent and strangulation of a hernia to be preceded by some intestinal disturbance, the signs of which may be suspended during the strangulation, and renewed after the operation. Whatever the disturbance, it may be treated, or left alone, as if no operation had been done; but it must not be forgotten in estimating the meaning of any symptom of ill doing.

Of these symptoms, one of the chief is vomiting. If a patient vomit once or twice soon after an operation for hernia, it may only be because the stomach was filled with secretions before the operation, and now finally empties itself. In this is no harm—perhaps some good. But, if the vomiting continue, it may be a sign of the gravest import. It may, indeed, be due to chloroform. I have seen several instances of this, and among them one in which chloroform-sickness continued for three days after the operation, endangering the patient's life. Generally you may distinguish the vomiting due to chloroform from that due to peritonitis or unrelieved strangulation, by its being attended with horrible nausea, like sea-sickness; by its producing no fæcal fluid or abundant gastric secretion, there being more retching than vomiting; and by the patient's feeling relieved of his hernia, however wretched he may feel with his nausea. If the pain and distress of the hernia be relieved by the operation, and except for vomiting all seem well, you may be nearly sure that the vomiting is due to chloroform, and commonly you must wait till it spontaneously subsides. I believe you cannot cure it, and food put into the stomach only aggravates it. The patient had better be without food, if in fair strength; but, if very feeble, he had better be maintained with enemata of milk, eggs, beef-tea, and wine.

If vomiting go on for six or more hours or for days, after the operation, and be not due to chloroform, it is a very bad sign—I had nearly said a mortal one; for generally it tells that the operation has failed in its design. Either the strangulation is not reduced, or the intestine is paralyzed above the strangulation, or there is peritonitis or sloughing or perforation of the intestine, or some such trouble. Very rarely the untoward conditions indicated by continuous vomiting are relieved spontaneously or with repeated doses of opium.

The persistence of abdominal distress, with tension and pain and colic, after the operation, is not so serious. If other symptoms be relieved, these probably will be; and they may generally be treated with large enemata or aperients, such as the sulphate and carbonate of magnesia. But there is no need of haste to

give these things. The abdominal troubles which they are to relieve are not due to serious disease, but probably to intestinal accumulation, which began before the strangulation, which would be very slow to destroy life, and may be allowed to remain till it can be treated without risk. In such a case as this—a not very rare case—when all seems well except the abdominal pain and tension, be on the watch. If there be no change, do nothing. With time, the intestines will empty themselves. If there be increase of pain, without increase of pulse or breathing or other evidences of fever or inflammation, give enemata or aperients. I am sure you may manage cases of this kind better and more deliberately than I did some of those which I have recorded. I see now that I was over-busy with them, and was only very fortunate in that I did no harm.

A large group of cases, much worse than these, may be made of those in which the operation gives little or no relief: all goes on after it as all did before, or everything becomes worse. Few cases can be more grave than these. You may think yourselves happy if, from twenty such cases, you can save one.

The failure of relief from the operation may be due to the utter exhaustion of the patient. I have had to operate on patients already dying. I could not refuse to operate, for I could not be certain that it would be useless; but it proved useless, and seemed mischievous. The intestine was returned, and all put right; but the patient was too exhausted, as one may say, to be conscious of relief, and went on dying, although carefully fed and nursed.

Or the failure of relief may be because the strangulation remains—a constricting band or misplacement of the intestine, or some such thing, having been overlooked. In such a case, especially if you have not opened the sac, you must open the wound and the sac; enlarge the opening through the stricture; find, if you can, the strangulated intestine or whatever may be wrong, and, if possible, set it right. You may be so fortunate as to succeed—more fortunate than I have been. But then, in two of my cases, an internal and distant strangulation coincided with that of the hernia. This was irremediable—could not be reached; and the second operation was as useless as the first.

But by far the most frequent cases in which the operation gives no relief, or only some slight and very brief relief, from the signs of strangulation, are those in which the intestine does not recover itself. It remains nipped, powerless, congested or inflamed, spoiled, and incapable of contraction; while the part of the canal above it becomes distended, and after a time powerless, the abdomen becoming constantly more tense, though it may be with less turbulence of the intestines. This condition is most frequent in the old, and after long strangulation; it is commonly attended with peritonitis; and no doubt the inflamed state of the muscular tissue of the intestine, both in and above the strangulated part, is often the cause of the loss of muscular power, or a serious hindrance to its recovery. But peritonitis is not a necessary part of the calamity. I believe I have had cases in which no peritonitis existed beyond the strangulated part. In such cases as these you may find the best hope, though the best is seldom good, in opium, food and wine, all of which you must give by the rectum, if the stomach will not retain them. Your object must be simply to keep the patient alive while, in time, the intestinal canal, being at rest, may regain power. Very small quantities of food may suffice for this—a few spoonfuls by the mouth every hour or two; and twice or three times a day, injections into the rectum of milk, beef-tea, egg, wine and laudanum, mixed all together.

Very similar to these cases are those in which peritonitis, having begun before the operation, is not relieved by it. There is plainly no reason why the relief of strangulation should at once remedy the peritonitis which the strangulation produced; and it sometimes seems to continue quite unaffected. Indeed, you had better expect that this will be so, and follow what is a very good general rule—that, namely, of giving opium directly after the operation in all bad cases of strangulated hernia unless there be some clear reason for not giving it. I have seen no harm come from

this plan, and I think it has sometimes done real good. What are the bad cases, I have already told you. In any or all of them, you may give a grain of opium, or an equivalent subcutaneous injection of morphia, directly after the operation; and then watch and determine whether to give more, or what else to do. Especially, you may expect to have to give wine very soon after the operation, for the patients are generally feeble.

Thus, then, you may have in mind four sets of cases in which the operation for strangulated hernia, though, to all appearance, well done, does no good at all, or too little to be counted. It may be so in patients utterly exhausted; in cases of persistent strangulation at the hernia or elsewhere; of intestine rendered powerless; of continuous peritonitis. Of all these I have seen examples. There may be others which I have not seen or have overlooked. From all of these you may distinguish in thought, and generally in fact and practice, those sets of cases in which untoward events arise after a clear interval of relief from the operation. All may go on well, or at least not badly, for a time; the patient may have a clear sense of relief; and the sickness and other bad symptoms may cease for hours or some few days; and then come trouble and disappointment.

The cases that may be thus grouped are many and various. I find among my notes instances of acute inflammation of the hernial sac and its coverings; simple acute peritonitis, such as might be called traumatic; asthenic peritonitis, probably of erysipelatous nature; acute peritonitis, with rapid collapse, from intestinal perforation or rupture; simple inaction or paralysis of intestine. And to those which were peculiar to operations for hernia may be added other calamities, such as might occur after any operation, as diffuse cellulitis, erysipelas, phlebitis, and others.

It is not possible to speak of all these things now—hardly even appropriate; for though those in the first list are associated with hernia, they are not peculiar to it, and their pathology and treatment must be studied on a broader field. The peritonitis must be dealt with according to the same rules as that which has nothing to do with hernia, using great care to determine which of the forms I have enumerated is in each case present. The strangulation may itself cause peritonitis; and this, as I have said, beginning before the operation, may continue after it. The wounding and exposure of the peritoneum may excite its inflammation, or greatly aggravate that which existed before the operation. In both these sets of cases, the signs of peritonitis will be observable directly after the operation, or, at the furthest, within twelve hours after it; and will generally be cases of acute, or, so far as the constitution of the patient will allow, of asthenic inflammation. But you may generally distinguish from these the cases in which peritonitis sets in after a longer interval, and in which it is rather of an asthenic type, whether it come from giving way of the intestine, or from such conditions as would produce erysipelas after external injuries.

Do not suppose me to pretend that, in every case of peritonitis after hernia, you can easily determine to which of these different types of inflammation it belongs. You can determine often; you should try to do so always; for according to the type of inflammation must be your treatment. In the sthenic inflammations, you may give great comfort and help to recovery by free local bleeding with leeches, by large poultices over the abdomen, by weak saline and alkaline drinks, by the plainest and least stimulating diet. In the asthenic, opium is the only remedy that is generally useful. It used to be calomel and opium; but I believe the calomel did harm oftener than good. And with the opium must be rest and warmth, and liquid nutriment, and diluted wine. And I can state no more general rules than these; for the rest of the treatment must be determined separately for each case.

Now, besides these very serious evils that may follow operations for hernia, some local troubles may ensue, of which a few are worth telling you of.

Perhaps the most common is acute inflammation of the hernial sac, alone or with the immediately adjacent part of the peritoneum. It is, I think, most likely to happen after operations for large herniæ

in old people, when considerable force or time has been used in the reduction. You may know it best by the localized pain and tenderness with acute fever, without the signs of unrelief or of general peritonitis of which I lately spoke. There is no severe illness, but the general condition appropriate to a sharp local traumatic inflammation; and you may treat it, in this view, with complete rest and warm moist coverings of the part, and very little food; and in the acute cases in robust people, with copious leeching. In the acutest case which I have seen, I applied ninety-eight leeches in three days after the operation, with great comfort, and I think great advantage to the patient. That was twenty years ago; but it would still be right to do the same.

Another local trouble is acute inflammation of the cellular tissue outside the sac. It is chiefly seen after operations for scrotal hernia, and for deep-seated femoral herniæ. Commonly, the case appears going on well for a few days; and then comes a blaze of inflammation in and beneath the skin, leading sometimes to abscess, sometimes to diffuse suppuration. There is in these cases nothing peculiar to hernia. The same troubles may, as you know, follow any other operation; and they always need the same general means of treatment. I have never seen serious evil ensue in any case of the kind.

I might tell of other hindrances to recovery from the operation for hernia; but I limit myself to those of inflammation of the testicle, of sloughing of the scrotum, and others which I have been able to study practically, and I pass the others by, as I have done many other things, especially the complications of herniæ with various local diseases, such as hydrocele, varicocele, undescended testicle, and others. I have seen only one or two cases of each, and can tell nothing which is not already well told about them. Indeed, for a conclusion, I must say that, though to some of you it may have seemed excessive to give four lectures on strangulated hernia, I have treated the subject very superficially, very incompletely. One lifetime is not nearly enough for its complete personal study, in even so large a field as this hospital supplies.—*Brit. Med. Journ.*, July 6th, 1872.

HOSPITAL NOTES AND GLEANINGS.

Notes of a Visit to the Surgical Wards of Hôpital la Pitié Paris.—In the course of a recent visit to the surgical wards of La Pitié, we observed various facts of interest.

Case of Luxation of the External Semilunar Cartilage.—The patient is a man aged twenty-seven, formerly a soldier in the French army. Some time before the last war he had a fall in which the knee was subjected to violent distortion. It became swollen, and during three months it was treated by means of blistering and tincture of iodine. During the war the patient was made a prisoner, and whilst in Prussia he fell one day in about the same way as the first time, and heard a cracking noise in the knee. Blisters, frictions, and a season at Amélie-les-Bains were uselessly tried, and for a year no change has taken place in the knee. The appearance of the leg is quite normal. The joint has preserved all its movements; there are no signs of effusion, and no rise of temperature in the knee. When the patella is made to move between the condyles a feeling as of rubbing of rough surfaces is perceived, and when the knee is half flexed there is a cracking noise heard whilst a foreign body is seen to bulge forwards. This foreign body is not an arthrophyte, or foreign body properly so called, and due to a disease of the cartilages as in dry arthritis; there are no signs of ossiform incrustation of the ligaments, etc. Neither does it present the appearance and circumstances of such portions of detached pieces of cartilage as are found in cases of traumatic lesions of the knee. Dr. Duplay thinks it is a case of luxation of the external semilunar cartilage, on account of the following signs: no foreign body can be made out, even on minute exploration; examination shows that an integral part of the joint moves out of place, and resumes its position as soon as a particular situation or point which stops its progress is passed; this point is the femoral condyle, which

is altered, as is the patella; the bulging perceived during semi-flexion of the knee can be caused by the semilunar cartilage only.

Dr. Duplay will not interfere actively or employ immobilisation, as the joint enjoys all its movements. As palliative means he will use compression of the knee, local sulphurous douches, and iodide of potassium internally.

Dropsy of the Knee; aspirating puncture.—The knee was punctured during our visit. A very fine needle was used, and eighty grammes (not quite three ounces) of liquid ran slowly into the receptacle. The puncture was quite painless. Pressure was exerted over the knee, so as to assist the issue of fluid. After this the patella assumed its natural situation. The after-dressing consisted in a heap of cotton-wool and compression by means of cotton bands.

Dr. Labbé remarked that it would take weeks to get out such a quantity of serous fluid by means of blisters.

Fistula Ani.—The case had been operated on a few days previously, and was doing very well. Dr. Labbé called attention to the infundibuliform shape of the anus and the existence of a bridle limiting the anus in the direction of the perineum, both of which are considered characteristic of venereal habits.

Fracture of the Arm; employment of Plaster Splints. — Dr. Labbé frequently uses plaster splints in cases of fracture of the limbs, as they constitute a very simple and handy appliance. In cases of fracture of the leg, only one long plaster splint, extending along the posterior surface of the limb, and taking in the heel and sole of the foot, is applied. In the present case of fracture of the forearm, the splint was applied along the extensor surface of the limb, and another splint was rolled three times round the forearm, leaving bare the seat of the fracture. In the space of twenty minutes the plaster was quite dry, and the splint had become hard and solid. Two wooden splints had been applied to keep the arm immovable whilst the plaster was drying.

The splints are prepared very easily. They consist of a piece of tarlatan (muslin gauze), cut according to the required size, and folded eight times so as to obtain the necessary thickness. The plaster must be very fine—plaster of Paris (as used by moulders). It is thrown into plain water, and when the liquid has absorbed enough of it, so that any fresh quantity would flour the surface, the preparation is of the necessary thickness. The splint is then soaked in the mixture and immediately applied.

Cysts of the Spermatic Cord.—The patient had a somewhat large cyst on each cord, so that the scrotum seemed to contain four testes. One of the cysts was punctured with a trocar in our presence. The liquid presented the appearance peculiar to spermatic cysts, and on microscopical examination was found full of living spermatozoids. A solution of tincture of iodine was injected.

Naso-pharyngeal Polypus in a girl of fifteen.—This was quite an unusual case of naso-pharyngeal polypus in a female. Dr. Labbé said he did not know of any other case on record. We saw the polypus operated on. The galvano-caustic knife was used, and the soft palate was slit neatly and quite clean. The tumour was then seen bulging forward, and was immediately removed by the galvano-caustic wire. No hemorrhage took place. The patient bore the operation very bravely. The growth was of the size of a small hen's egg.—*Lancet*, Oct. 19, 1872.

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Hospital Notes from Birmingham.—An interesting case of recovery after fracture of the base of the skull has recently left the wards of the Queen's Hospital. A woman, aged forty, fell down a flight of stone steps on to her head. Profuse bleeding from the ears and nose ensued, and subsequently vomiting of blood. The patient was semi-comatose for forty-eight hours, and had a continuous discharge of cerebro-spinal fluid from the left ear for nine days.

Mr. West has a case of chronic synovitis of both knee-joints under his care, in which, after the failure of a variety of plans of treatment, both internal and external, he has done great good by introducing the largest canula of the aspirator, and draw-

ing off two ounces of brownish serum from each joint. No constitutional irritation was set up by the operation, and the man, aged forty-two, was able to leave his bed at the end of a week, and to walk about.—*Lancet*, Oct. 5, 1872.

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Treatment of Phagedenic Chancres by Continuous Irrigation.—Mr. Jonathan Hutchinson, Senior Surgeon to the London Hospital, in the treatment of phagedenic chancres, has for some time, with very good success, used the continuous bath. The patient is ordered to sit in a hip-bath with tepid water for the greater part of the twenty-four hours, a few hours being allowed for sleep. The water is changed as often as it becomes uncomfortably cool. This treatment is kept up until all phagedenic action ceases, and the sore shows a perfectly healthy surface. It may or may not be necessary to apply fuming nitric acid to the sore in addition to the bath, but in some cases the cleansing action of the water alone is quite enough. Mr. Hutchinson attaches great importance to a frequent change of the water in contact with the sore, and lately he has directed the patient to keep a continual stream of water from an irrigating apparatus playing on the ulcerated surface while in the hip-bath. By this means, every particle of contagious phagedenic discharge is removed as soon as it is secreted, and the formation of a healthy surface is much accelerated.

In a case lately under care, the patient, a man aged 40, was admitted with a chancre which had probably existed about a month, and been phagedenic for about ten days. It was a very large sore (2½ inches by 1½), situated on the upper surface of the prepuce; its base was ashy, its edges overhanging, and a large slough was attached to part of its surface. It was evidently spreading fast. The patient was put into the continuous bath, with orders to keep a jet of water from the nozzle of an irrigator constantly playing over the sore. After a little more than three days (eighty hours) of this treatment, without any other local application, all trace of sloughy discharge had ceased, the ulcer showed a healthy surface and had begun to heal at the edges. Its after-course was equally satisfactory, and he left the hospital twelve days after admission, quite cured as regards the chancre.—*Brit. Med. Journ.*, Nov. 2, 1872.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Successful Local Treatment of Diphtheria. By Henry Reynolds, M.D., of East Wilton, Maine.—In the autumn of 1871, having had several cases of diphtheria, and lost the first two, I was led to try carbolic acid crystals and glycerine, equal parts, freely applied by means of a wisp of cotton, upon the end of a probe, dipped in the solution. This application was repeated, once or twice a day, according to the severity of the case, or the rapidity of the formation of the exudation. About ten cases have been treated by this method, and every one has progressed well and terminated favourably. Before adopting this method I had had three cases, two of which had died, and one, Case I., remained then under treatment. Having some fears for the result in that case, I applied the carbolic acid solution, the amendment was speedy and the patient recovered. I do not claim that this remedy has been tested in a sufficient number of cases to establish its *infallibility*. All that is claimed is that its apparent success has been such as to entitle it to a more extensive trial that its true value may be determined.

Case I.—Minnie C., aged 8 years, came under treatment Aug. 8, 1871. Had exudation upon both tonsils, thick and leathery, and thinly over the uvula. During the next eighteen days, she was given tonics, quinia, carbonate of iron, tr. chloride of iron, chlorate of potassa, and gargles of astringents, and antiseptics. Milk diet principally. Exudation diminished in amount and then increased, accompanied with vomiting of food.

26*th*. Treatment continued essentially the same, excepting that to-day, for the first time, applied solution of carbolic acid crystals and glycerine, equal parts, to the

patches of exudation, and continued daily until there was no further exudation.

Sept. 1. During convalescence, she was affected with partial paralysis of the muscles of deglutition, and partial loss of voice, from which she fully recovered in a few weeks.

The query suggested to my mind in this case is, would there have been the subsequent paralysis if the application of this powerful antiseptic had been applied daily from the first?

Case II.—Otis N., aged 8 years (brother of a girl older, who was one of the cases which I lost two days before), was taken sick, August 24th, with vomiting and sore throat, followed by small patches of exudation upon the left tonsil. I applied the carbolic acid solution twice a day. Internally, gave tr. chloride of iron and chlorate of potassa gargles, milk diet, and kept in bed.

26*th.* No exudation upon the right tonsil, upon the left tonsil it was held in check by the applications.

27*th.* Membrane has disappeared from the left tonsil.

Sept. 5. Discharged well. No sequels.

Case III.—J. P. S., a young man, aged 20 years. Sept. 1. Patches of exudation upon one tonsil. Applied daily carbolic acid solution; internally gave tr. chloride of iron, chlorate of potassa, and milk diet.

2*d.* Membrane appeared upon the other tonsil. Treatment the same.

3*d.* Membrane disappearing from first tonsil.

5*th.* No membrane upon either tonsil. Discharged.

Of the other seven cases, which it seems unnecessary to give in detail, some were sick from seven to ten days, but, under a treatment essentially the same as the above, the patients progressed favourably and recovered without sequelæ. The glands of the neck of all these cases swelled but very little. The treatment was commenced early, the importance of which cannot well be exaggerated. I infer that, to insure a successful termination, it is essential to commence the local application of carbolic acid upon the first appearance of the disease, and repeat often enough to maintain a thorough antiseptic action, and use the solution of sufficient strength to control the exudation.

Complete Inversion of the Uterus successfully Replaced. By J. D. Southard, M.D., of Raymond, Union Co., Ohio.—During twenty years' practice the following is the only case of complete inversion of the uterus which I have met with.

March 13th, 1869, I was called to see Mrs. W. J., aged 29, a farmer's wife; small but healthy; the mother of five children. The accident happened four hours previous to my arrival. On removing the bedclothes I found the uterus inverted and placenta attached. There was no hemorrhage. I removed the placenta, then, grasping the uterus in my left hand, passed it up the vagina to its proper position, my hand entering the uterine cavity. Feeling satisfied that all was right, I instantly removed my hand.

The patient during this time made but little complaint, sustained no perceptible shock, lost but little blood, made a speedy recovery, was confined May 1st, 1872, and enjoys good health.

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Death from Chloroform.—Dr. W. W. Dawson records (*The Clinic*, Oct. 26, 1872) the following case communicated to him by Dr. Roll of McGonnigle's Station, Butler Co., Ohio, in whose practice it occurred.

Mr. D., aged about 60, had about a drachm of chloroform administered to him June 25, 1867, for removal of caries of tibia. As the result of the inhalation of chloroform, the patient's leg became rigidly drawn up, and at the same time the body being suddenly and rigidly raised to a sitting position, which soon passed off, and with it pulsation ceased, and life was extinct. All efforts at resuscitation were unavailing.

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Repeated Smallpox.—A woman recently died in Boston of smallpox who had, only twelve weeks previously, recovered from an attack of the same disease. In the first instance, she gave the disease to several others in the family; in the second it took on the hemorrhagic form.

Not many months ago a child, not over a year old, died in Boston of a well authenticated second attack of smallpox.

These cases show that recurrence de-

pends upon individual susceptibility, and not on the length of the interval between the two exposures to contagion. In other words, it is not a "wearing out" of protection that causes the second attack.—*Boston Med. and Surg. Journ.*, Oct. 21, 1872.

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Philadelphia College of Pharmacy.—The attendance at the lectures in this institution at the present term is stated to be so large that it has been necessary to provide additional seats; and the applications for laboratory instruction have been so numerous that the twenty tables for the accommodation were insufficient, and twelve additional are being added.

FOREIGN INTELLIGENCE.

Guarana in Sick Headache.—Mr. Samuel Wilks, of Guy's Hospital, writes to the *Lancet*, Oct. 5, 1872, of the virtue of guarana in sick headache. So many of his patients have spoken so positively of the relief which they have obtained that he has no hesitation in attributing the effect to the remedy.

He writes: "I am now seeing a lady who speaks most enthusiastically of it, as she has not had a headache for nearly six months, having on several occasions warded it off by the guarana. I have in my note-book several other cases where the same positive statement is made. I have now before me two letters just received from young ladies living respectively in London and Ipswich. The one says: 'I have found great benefit from the guarana powders which you recommended me; they almost invariably cure my headache.' The other lady says: 'When you prescribed guarana powders for me last May for severe and frequent headache, you asked me to write and let you know if I found them beneficial. I have every reason to believe them a complete preventive of headache, as on the least symptom I have taken a powder, sometimes a second, in two hours of a time, and in no case have they failed as an effectual cure. I have not had a bad headache since I saw you.' I quote these letters as evidence of the value of the remedy in some cases, and that it is worth an extended trial."

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Abortive Treatment of Boils and Whitlow.—Dr. Simon de Forges (*Rev. de Thérap.*) advises the topical use of camphorated spirits as an abortifacient in boils and whitlow. In the former case the boil is to be rubbed eight or ten times by the finger dipped in the alcohol. He asserts that it is rare that after this treatment a boil goes on further towards suppuration. In cases of whitlow he advises the patient to dip the finger for some ten minutes in camphorated spirits. This almost always gives great relief of the pain, and often cures the complaint.—*Medical Press*, October 30, 1872.

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Orchitis treated by Absolute Rest.—Dr. Brambilla gives in the *Gazetta Medica Lombardia* (September 21) an account of the results of the treatment of orchitis by mere rest, which has been put into force by Dr. Fiorani at the Ospedale Maggiore at Lodi. After passing in review the various means that have been hitherto employed, and usually with a considerable loss of time, he observes that Dr. Fiorani, being under the conviction that some of these owed whatever efficacy they possessed to the absolute repose which they enforced upon the organ, resolved to try how far mere rest would succeed. By the employment solely of the most absolute rest he has treated with success twenty-two cases of orchitis, twelve of these being gonorrhœal, six traumatic, and four idiopathic. In all of these the cure was complete, in one only it being necessary to apply on the sixth day some mercurial ointment on account of slight induration of the epididymis. By absolute rest is meant that the patient should lie continuously on his back, with a small cushion between the thighs, in order to support the testes, and that he must never get off his bed even for the purpose of his natural wants. The pain ceased soon after the position was assumed, and in a few days the testes lost all sensibility, the swelling and heat also disappearing. The medium time occupied in treatment was five days, although on admission the af-

fection had lasted from two to five or six days, and the testis had acquired from two to five times its normal size. Among the traumatic cases one remained in the hospital for twenty-four days, the orchitis being complicated by severe ecchymosis of the scrotum. One of the gonorrhœal cases also lasted twelve days, but none were dismissed until the testis had entirely reacquired its normal condition. These cases were observed by numerous practitioners, and the patients could be readily found for verification. Dr. Brambilla therefore concludes that orchitis can be more rapidly and more effectually cured in this way than by any of the ordinary remedies, and that in thus treating it by absolute rest we are only imitating nature.—*Med. Times and Gaz.*, Oct. 12, 1872.

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Method of Aspiration for the Removal of Fluid from Closed Cavities of the Body.—M. Bouvier, in a note presented to the French Academy of Sciences, claims for M. G. Palletan, the credit of priority in the employment of this method. This last-named surgeon in 1831 communicated to the Academy of Medicine a memoir on the subject, with the instrument he employed, and in 1836, after a long discussion on empyema, he presented again his memoir and instrument to the Academy. M. G. Palletan's memoir was not published, but his instrument is described in the *Journ. de Chimie Médicale*, 1836, p. 105, and a notice of his memoir was made in the *Archives Gén. de Méd.*, vol. xxv. p. 272, 1831, and in the *Bull. de l'Acad. de Méd.*, vol. i. p. 237, 1836.

—

Acute Glaucoma.—Dr. Le Fort read a paper on this subject before the medical section of the French Association for the Advancement of Science at its late meeting in Bordeaux, in which he combated the theories of Von Græfe and Hancock, and rejected the therapeutic means proposed by these two celebrated oculists—iridectomy and the section of the ciliary muscle. According to Dr. Le Fort, acute glaucoma is anatomically characterized by a veritable dropsy of the serous tissue which separates the choroid from the sclerotic. He showed how this lesion explained all the symptoms of acute glaucoma; and he prefers, as a means of treatment, the sclerotical paracentesis of the eye. Twice already this method has been employed by him, and it has been followed by a very prompt and happy result.—*Brit. Med. Journ.*, Sept. 28, 1872.

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Paralysis of various Organs, due to Disease of the Heart.—At the last meeting of the Société Biologique de Paris, M. Joffroy, house-surgeon to La Pitié, presented a patient suffering from paralysis of various organs, due to disease of the heart. The patient's history is briefly this: He is seventeen years old. In March, this year, he suddenly lost the sight of one eye; and a few days after he showed confusion of mind, difficulty of mastication, and almost complete hemiplegia. He was then taken to the hospital, and the following lesions were observed: complete paralysis of the lower part of the face; tightness of the jaws; almost complete immobility of the tongue, whence the difficulty of mastication, deglutition, and the articulation of words. The eye was affected with amblyopia, and on being examined with the microscope was seen to present considerable anæmia of the retina. Hemiplegia was very marked in the limbs. On examining the heart an intense bruit de soufflé, during the first sound, was discovered. This bruit disappeared and came according to the various attitudes which the patient was made to assume. Pulse and respiration normal. The various symptoms increased in intensity, and it was quite impossible for the patient to take food. Finally, by means of the œsophageal sound, food of various sorts was introduced into the stomach. The patient has since that time gained strength, and the symptoms have amended; contraction of the buccal muscles can be excited; deglutition is now possible; the tongue, however, is still immobile, flat and smooth, and suggests the idea of atrophy.

M. Joffroy thus explains the causation of the various symptoms just described. In the situation of the left auriculo-ventricular orifice there is a floating polypous

production giving rise to the variable bruit de soufflé; embolisms thrown into various parts of the brain; through the vertebral arteries into the region which commands the movements of the mouth, tongue, and pharynx; through the arteries of the brain into the hemisphere opposite to the hemiplegic side; through the ophthalmic into the retina.—*Lancet*, Sept. 7, 1872.

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Sudden Death.—Dr. J. Milner Barry, of Tunbridge Wells, relates (*Brit. Med. Journ.*, October 5), three cases of this. The first occurred in a man, aged 41, who during life had only complained of dyspeptic symptoms, including a peculiar choking sensation coming on at nights, and relieved by walking about. The heart and lung sounds were apparently normal. Death occurred suddenly in the night. At the post-mortem examination the left pleura was found full of blood, which had escaped from a small sacculated aneurism, the size of half a walnut, of the descending portion of the thoracic aorta situated behind the heart. The case was characterized by a singular absence of the usual concomitant symptoms of aneurism. There was no dysphagia; no erosion of the vertebræ. The choking sensation might be accounted for from the fact of the œsophagus being attached to the aneurism, lying directly on it. Dr. Barry mentioned that both Dr. Stokes and Dr. Walshe refer to the extreme difficulty of positive detection of small aneurismal sacs behind the heart.

The second case occurred in a young lady, aged 21, active, well-nourished, and with a good healthy colour. She was subject for nearly twelve months to nearly constant vomiting, and known to be the subject of heart-disease. On auscultation, loud blowing murmurs were heard over the pulmonary aortic and mitral valves, a thrill was perceptible over the situation of the pulmonary valves, and the area of præcordial dulness was increased. The vomiting continued unchanged, and, though apparently somewhat hysterical in character, seemed mainly attributable to irritation of the pneumogastric nerve from the diseased heart. She died suddenly in the night. At the post-mortem examination the pericardium was found generally adherent. The tricuspid and aortic valves were healthy. Two of the pulmonary valves were adherent by thin edges, and one of the mitral valves shortened and tied down. A short funnel-shaped canal passed through the septum ventriculorum from below the aortic valves to behind the tricuspid. Two rough ridges, one above and the other below the opening, probably impeded and roughened the current of blood, and gave rise to the peculiar "swashing" character of the murmur heard during life. The direction of the canal was such as to cause the blood to pass more readily from the left ventricle into the right than *vice versâ*. The entire absence of cyanosis was a noticeable feature in this case. No ulceration was found in the stomach; but there appeared to be a sort of constriction midway in the greater curvature, where probably the spasmodic action was greatest, and this may have accounted for the peculiar character of the vomiting; the food being suddenly and forcibly shot out, and, in the convulsive effort made to reject it, a portion was probably dashed on towards the pyloric end, and then retained till the vomiting had subsided, thus, in a measure, accounting for the nutrition of the patient being maintained.

The third case occurred in a single lady, aged 41, five months previously. Dr. Barry had attended her with chronic peritonitis; from this she quite recovered, and had never complained of any chest-symptoms. She died suddenly whilst dressing. At the post-mortem examination the pericardium was found distended with about eighteen ounces of serum and soft blood clots. The heart was loaded with fat, and flabby, and showing fatty and granular degeneration, and almost total disappearance of muscular striæ under the microscope. The aorta was stiff, rugose, atheromatous, and dilated. A small aneurismal pouch, one inch above the aortic valves, as thin as a wafer, had given way, and allowed an escape of blood into the peritoneum. This patient's brother had died suddenly some months previously at the age of 52. The clinical lesson taught by

the above and similar cases, as Dr. Barry insisted, was that, in cases of extremely sudden death, our attention should be directed to the heart first, and not to the brain.

—

Deaths from Chloroform.—Dr. L. W. Marshall, of the General Hospital, Nottingham, records (*Brit. Med. Journ.*, Oct. 12, 1872) the following case:—

J. T., stout male, was admitted into the Nottingham General Hospital with a compound comminuted fracture of the left leg. Amputation was resorted to; he did not appear to be suffering from shock; and the quantity of blood lost, although large, was not so great as might have been expected from the nature of the injury. About three drachms of chloroform were administered. Face became livid; the tongue was thrust between the teeth, and respiration ceased, but was immediately resumed on removal of the tongue by forceps. He continued to respire with ease, and became partially conscious. A few minims more chloroform were inhaled. Ten minutes later the respirations were more shallow and less frequent; suddenly face became livid, teeth firmly fixed, and respiration ceased entirely. All efforts at resuscitation were fruitless.

Heart was found to be pale and empty; mitral valve was slightly thickened, and there was atheromatous deposit in the aorta. The stomach was half full of partially digested food; the pharynx contained some of this.

Mr. William Bird, of York, records in the same journal another case. Mrs. C., aged 57, was operated upon for tumour of head. Less than half a drachm of chloroform was administered on a sponge. A second half-drachm was added, and, within a minute after, the pulse suddenly stopped, the breathing then ceased, and the countenance became livid. Efforts at resuscitation were of no avail.

—

Death from Bichloride of Methylene.—A case of death after inhalation of this substance occurred at Middlesex Hospital on Oct. 9. The patient, a man aged 48, was admitted for a deep abscess in the buttock, discharging a short way within the sphincter ani. He was apparently healthy. It was thought desirable to lay the abscess open, and, if necessary, to complete the operation as for fistula. Methylene was used on this occasion: about two drachms had been inhaled, and he was insensible; when, as the operation was about to be commenced, and a minute after the inhalation had been stopped, it was noticed that his breathing had ceased, and he became very livid. Silvester's method of keeping up respiration was at once resorted to, and he gasped once or twice. Galvanism was employed, but no effort produced any effect. The only *post-mortem* condition of importance was the existence of a rather large and very flabby heart.—*Brit. Med. Journ.*, Oct. 12, 1872.

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Reaction of Leucæmic Blood.—In one of the last parts (Heft 1, Band viii.) of the *Zeitschrift für Biologie*, Dr. Mosler states he has had an exquisite case of splenic leucæmia under his care, and that on examining the reaction of the blood he found that it did *not* present, as has sometimes been stated, an acid reaction. On the addition of a little tincture of litmus, and exposure to a warm room, the colour turned red after four days. The defibrinated blood placed in a graduated tube with twenty-four divisions, and allowed to remain at rest for twenty-four hours, gave the following results: 1. The upper layer of clear serum occupied five divisions; beneath this was a layer of colourless blood-corpuscles occupying seven divisions, and the remaining twelve were occupied by red blood-corpuscles. The proportion of the white to the red corpuscles was thus very nearly as 1 : 2. The patient was forty-four years old, from Uckermünde, who had had ague twenty years, and again eight years, previously. A year after presenting himself he had pain and a swelling in the left side. He had well-marked retinitis leucæmica. He was treated, apparently successfully, with cold douche baths directed to the region of the spleen and with large doses of quinia.—*Lancet*, Sept. 28, 1872.

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Consultation with Homœopaths. — "A physician practises medicine not for the

sake of solving puzzles, but of saving patients."..."If a diseased person, who in his ignorance submits himself to the homœopathic delusion, find the wit of his homœopathist obviously dull on the nature of his disease, and desire a physician to sharpen it, in order that the homœopathist may with the greater ease of mind practise upon the patient with globules, the physician obviously may and ought to decline to be a party to any such mischief. The physician who consents to 'diagnose' a disease for a homœopathist becomes a party either to a folly or to a fraud. It weighs nothing, in the decision, that the patient, in his ignorance, is willing to be defrauded or be fooled. He is free to make such a choice: we are not free to assist him in it. A physician is only called upon to exercise his calling when and as his conscience approves it. *Toujours prêt* is an excellent motto for a cabman. When duty calls, and as conscience bids, is the rule for medical workers. It is an individual harm to each patient that he should submit to the delusion, and we are called upon to have no part in it. It is a general injury, and tends to propagate the error that homœopathists have any claim to scientific consideration or footing of professional respectability (we mean always scientifically, and not personally or socially), that a physician should consent to do anything which could bear the semblance of a consultation with a homœopathist, or a recognition of any claim on his part to be a rational therapeutist, or to possess any claim to rank or associate with healers and physicians. Homœopathy, which began as a delusion, is now rapidly ending as a fraud. The ignorant delusion that all diseases were varieties of the itch, which was a cardinal point of homœopathic belief at the outset, has faded before the discovery of the itch-insect. The mystic folly of extreme dilutions, the potency of increasing weaknesses, the value of direction in shaking and stirring, are fading follies likewise; their place is being taken by frauds. We hear now of castor oil and hydrate of chloral, tincture of aconite and tartar emetic, in heroic and almost poisonous doses, to produce purgation, give sleep, reduce the heart's action, and promote secretion. It no more becomes us to assent to a fraud than to yield to a delusion; and now more than ever, perhaps, must it be held disgraceful for a physician to hold any direct or indirect intercourse with a homœopathist, whether 'hard-shelled' or 'soft-shelled,' globulist or trimmer."—*Brit. Med. Journ.*, Oct. 26, 1872.

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Juvenile Smoking.—Whatever opinions may be entertained as to the effects of moderate tobacco-smoking on the adult, there can be none as to its deleterious influence on the boy. The molecular changes coincident with development of tissue are interfered with, slowed, if not arrested by tobacco. Take the blood-corpuscles, for example, and see how the narcotic affects them. According to German physiologists, they lose their round shape and become oval and irregular at their edges; while, instead of mutually attracting each other, and running together in *rouleaux*—a good sign—they cohere loosely, or lie scattered on the field of the microscope—a bad one. The physical effects are paralleled by the psychical ones. M. Bertillon found that, of the pupils attending the Polytechnic at Paris, 102 smoked, while 58 did not. Arranging the two categories in the order of merit, according to the results of the examinations, he found the non-smokers held, in every grade, the higher rank; and that the smokers, as compared with the non-smokers, deteriorated from their entering to their leaving the school. Facts like these induced the Minister of Public Instruction, in 1861, to issue to the directors of colleges and schools throughout the empire a circular forbidding tobacco to the students, on the ground "that the physical as well as the intellectual development of many youths has been checked by its use." In Germany, where at so many schools the Bursch's ideal may be summed up in Goethe's lines—

"Ein starkes Bier, ein beizender Taback
Und eine Magd im Puss, nun das ist mein Geschmack,"

the premature smoking of tobacco would, but for the superior stamina of the race,

prove not less disastrous. As it is, tobacco amaurosis is an ophthalmic affection quite recognized by German physicians as having its origin at school and college. Amongst ourselves juvenile smoking is getting more and more common, with the result of impaired eyesight, thinning of the hair, and other symptoms of excessive draughts on the trophic nerve-centres.—*Lancet*, Oct. 5, 1872.

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Preservation of Bodies for Dissection at the London Colleges.—For the information of those of our readers who are engaged in the study or teaching of anatomy and operative surgery on the cadaver, we transcribe from the *Lancet* for Oct. 5, 1872, the following directions for the preservation of bodies, as pursued at two of the principal London colleges.

At *Guy's* the bodies are preserved by a method given in detail by Mr. Howse in the "Guy's Hospital Reports" for 1872. The process consists in injecting into the femoral artery of one or both sides of the body about three pints of glycerine, in which one pound and a half of arsenic has been boiled, and in two or three days forcibly injecting, by means of a syphon, about two gallons of pure glycerine. By this means the glycerine is made to permeate all the tissues of the body, bullæ containing glycerine not unfrequently forming on the skin. It is necessary to attend to the condition of the fingers and toes, for at first they swell up and become plump, but, if left for a few days, they shrivel and dry up. This shrivelling is entirely obviated by injecting a further quantity of glycerine into the arteries. The bodies are then laid aside and covered with cloths soaked in carbolized glycerine, or are imbedded in sawdust soaked with carbolic acid. The red paint may be employed at any time, but it is well to wait for a few days after the injection of the glycerine before using it. The bodies are in good condition, the skin has become dark, but the muscles are of a good colour, and firm, and the nerves sufficiently tough to be readily traced out. This method, like the preceding one, is not well adapted for bodies in which a post-mortem examination has been made. The most serious objection to this process, however, is the cost, which is at least thirty shillings for each body.

At *St. Thomas's* the method adopted is identical with that used by Professor Marshall, to whom the authorities at this school are indebted for the details. In this process the arteries may or may not be injected with a weak solution of arsenite of potash, but Mr. Marshall objects to large quantities of arsenic being used, one or two ounces being quite sufficient for the purpose. The bodies are then immersed in a fluid consisting of twenty-four gallons of water, twenty-eight pounds of common salt, one pound and a half of nitrate of potash, and three pints of Burnett's fluid (chloride of zinc) to each body. After many trials these proportions have been found to be best adapted for preserving bodies for dissection, for if too much salt or nitrate of potash be used, the skin gets very hard. By this means Mr. Marshall has been able to preserve portions of the body in good condition for demonstration for a period of ten years. This method seems to be the best that we have yet seen; it has the further advantage of being the cheapest, and we understand that the fluid in which the bodies are immersed need only to be changed once in several years. If this process be adopted, it is advisable to inject the paint within a few days of immersion.

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Transfer of the Faculty of Medicine from Strasburg to Nancy.—This transfer has been confirmed by a decree of the President of the French Republic dated Oct. 1, 1872.

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Gazette Obstetricale—This is the title of a new journal, edited by Dr. Verrier, which has just been issued in Paris, and is to be published semi-monthly.

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Obituary Record.—Died on the 24th October, 1872, aged 55 years, Dr. Daremberg, Professor of the History of Medicine in the Faculty of Medicine of Paris, Librarian to the Mazarine Library, member of the Academy of Medicine, etc. etc.

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